Healthy Maine 2010: Opportunities for All

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Goals, objectives, major narrative points,
and health disparity issues chosen by
over 500 Priority Area Work Group Members
and other statewide experts

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A CALL TO ACTION

The information contained in *Healthy Maine 2010: Opportunities for All* calls us to action.

We are called to assure that every Maine child – rich or poor, black or white, rural or urban – has the same opportunity for a healthy smile with a full set of teeth.

We are called to assure that disabled veterans have the same opportunity for accessing health care appointments as our other neighbors.

We are called to assure that our fellow students and co-workers – gay, lesbian, bisexual, transgender, or straight – have the same opportunity to be safe from injury.

We are called to assure that all our youth and young adults, regardless of parental income or ethnicity, have the same opportunity to live tobacco-free with a healthy diet and regular physical activity, and to have access to mental health services.

We are called to assure that all Maine people, regardless of age, disability status, gender, life situation, residence, race or ethnic background, sexual orientation, or socioeconomic status have the same opportunity to live longer and healthier lives.

If Maine people are to have an opportunity to live longer and healthier lives, we must focus our efforts not only on specific goals and objectives, but also on groups of people whose health status is poor relative to others. While the priority area chapters of *Healthy Maine 2010: Longer and Healthier Lives* answer the question "**what** are our priorities?", giving us a road map of priority area goals and objectives, *Healthy Maine 2010: Opportunities for All* answers the question "**who** are our priorities?", with a focus on those populations facing health disparities.

What are health disparities? Poor health status in our country is often associated with being a member of a population group whose definition has little to do with health per se. For instance, it is well documented that people in our country who are a member of a racial minority or who earn low wages suffer poorer health status, even though skin color and low wages do not themselves biologically or directly cause poor health. These inequalities in health status are also known as health disparities.

Although there are numerous factors that place us into a population group that can lead to health disparities, eight are focused on in *Healthy Maine 2010: Opportunities for All*: age, disability status, gender, life situation, residence (rural or urban), race and ethnicity, sexual orientation, and socioeconomic status.

A Call To Action

Perhaps Carl Toney, P.A., Assistant Professor at University of New England in Biddeford, articulated Maine's challenge to addressing minority health issues best when he said, *"The issues of cultural diversity are complex, and to some threatening. In the absence of accurate, appropriate, and comprehensive racial and ethnic data, Maine is like a great ship – taking on an unknown number of passengers, heading into unchartered waters, for a destination undetermined. If we make a sincere effort, use the proper tools as provided by the right data, we can assure the safety of both the ship, and most importantly, its passengers."* What Professor Toney says about racial and ethnic data is also true for all factors that result in health disparities – until we have the proper tools, we cannot assure the health of all Maine people.

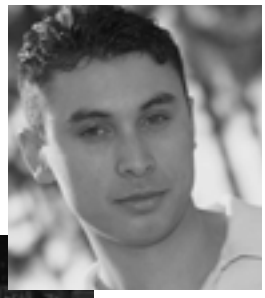
Each factor is addressed in a separate chapter. It is important to note that these factors overlap a great deal, especially socioeconomic status with most other factors. For instance, children, people with disabilities, women, racial and ethnic minorities, and residents of rural areas are all more likely to live in poverty. However, even when correcting for the effect socioeconomic status has on health, these other factors have been shown to impact health status.

Lack of pertinent data and resources do not permit a thorough analysis of each of these factors and their separate impact on health status in Maine at this time. However, it is desired that *Healthy Maine 2010: Opportunities for All* raise awareness of these issues and be a catalyst for change:

- **a catalyst to help us understand and address the challenges we face in measuring the impact these factors have on the health of Maine people;**
- **a catalyst to help us more effectively identify priority populations, not just in terms of a geographic area we serve, but also in terms of population groups that face inequities in health;**
- **a catalyst to help us utilize our health resources more effectively to reach out to those with poorer health status;**
- **a catalyst to help us evaluate our public health interventions and, as a result, shift our efforts appropriately; and most importantly,**
- **a catalyst to help us assure that all Maine people have an opportunity to live longer and healthier lives.**

We are called to ensure that all interventions having an impact on health, have an impact on reducing inequalities in health.

Why is this call to action important?



First, we need to identify populations that face health inequalities in order for our resources to be used as efficiently as possible. Just as a company selling cars buys commercial television time on shows watched by people who may be buying cars and not on children's shows, our public health efforts, in order to be most efficient, need to be focused on those in greatest need. Although a number of dedicated public health and other professionals have tried to reach out to populations facing disparities in Maine, we have few mechanisms to measure our effectiveness in addressing these health inequalities.

Second, health status goals and objectives cannot be met unless we address inequalities in health. For instance, we cannot substantially lower our tobacco addiction rates unless we effectively focus on the populations with the highest rates – people living with low wages, young adults, and Native Americans.

Third, inequalities in health status lower the health status of others. For instance, children with poor access to water fluoridation and school-based dental sealant programs in rural areas of the State will utilize a bigger proportion of dwindling dental resources as adults, thereby affecting everyone's access and dental health. Higher and increasing rates of HIV among some sub-populations (such as some racial or sexual orientation minorities) mean that even majority populations face a greater chance of contracting the infection.

"The gap between rich and poor widens when life expectancy is divided into years in good health and years of disability. In effect, the poor not only have shorter lives than the non-poor, a bigger part of their lifetime is surrendered to disability."

From The World Health Report 2000

Fourth, addressing these inequalities is the just course of action. Justice is better served if our public health system, like our public education system, is based in the belief that all children, regardless of disability status, gender, parents' occupation, place of residence, race and ethnicity sexual orientation, or parental income should have the same opportunities.

Addressing inequalities in health status also gives us exciting opportunities to learn more about each other – about our cultures, our histories, and our passions. Strategies that address health disparities also strengthen bonds between groups of people. If bonds are strengthened between rich and poor; black, brown, and white; veteran and non-veteran; gay and straight; Native American and non-Native, then aren't we all the better for it? Indeed, not only can more of us enjoy the opportunity of a longer and healthier life, but also Maine can become the richer for it.

How to Use *Healthy Maine 2010: Opportunities for All*

Each chapter in this book covers one of eight selected factors that commonly lead to health disparities: socioeconomic status, race and ethnicity, age, disability status, gender, life situation (with a focus on veteran status), geographical residence, and sexual orientation.

Each chapter has several sections:

- **"Nationally We Know" contains national information on the factor and its impact on health. The source for the health data contained in this section are from US Department of Health and Human Services' *Healthy People 2010* unless otherwise noted.**
- **"In Maine We Know" contains Maine-specific information on the factor, including current ways to identify populations that face disparities and this factor's impact on health status in Maine. Unless otherwise noted, health data contained in this section are from the Bureau of Health.**
- **"Challenges" contains a summary of challenges faced in Maine in measuring the impact the factor has on health status. This is not a section summarizing the challenges faced by specific populations, since this is partly covered by the first two sections.**
- **Because there is often a scarcity of health data measuring the impact these factors have on health, each chapter contains some perspectives from one or several State experts on the health issues of the specific populations covered.**

It should be noted that the information contained in this book on each factor is not comprehensive. Resources do not permit a comprehensive review at this time. However, it is hoped that enough information is contained here to be a catalyst for further discussion, engagement, and change.

SOCIOECONOMIC STATUS

- Socioeconomic status (SES) is a term that refers to a combination of income and other social measures that include education level attained. The term SES also refers to some of the less measurable factors often associated with poverty such as social exclusion, which includes lack of a supportive community environment; overall high stress levels often associated with trying to find adequate food, shelter, and clothing; and exclusion from decision-making civic participation.
- Inequalities in SES, primarily measured by income and education, underlie many health disparities in the US.
- Income and education are intrinsically related and serve to some degree as proxy measures for each other. Therefore, those people who attain high education levels are more likely to attain high income levels as well.

According to the World Health Organization and others, research indicates that socioeconomic status is one of the *strongest* determinants of health, but the health of a population appears to be more determined by the *distribution* of income rather than the overall wealth of the population.

(*World Health Report 2000*, WHO)

Christine Hastedt, Public Policy Specialist, Maine Equal Justice Project

"Despite the good work that's been done over the past several years, there are large numbers of people who cannot afford private coverage and are not eligible for a public program. A related problem is ensuring that people with MaineCare Insurance (Medicaid) have genuine access to quality services. Areas of particular concern include dental care and care for children with mental health problems."

NATIONALLY WE KNOW:

- Higher SES, as measured by higher income and education levels, allows people in the US increased access to medical care, better housing, safer neighborhoods, and opportunities to choose healthy behaviors such as physical activity.
- Lower SES, as measured by lower education and income status, is associated with higher rates of incidence and death from heart disease, diabetes, obesity, lead poisoning, and low birth weight.
- Limitation in activity from chronic disease, the most common underlying cause of disability, is three times higher in people with low income than in those with the highest income levels.
- Cardiovascular disease, the biggest cause of death, showed a decrease in mortality for all SES groups in the US between 1969 and 1998. However, there were significantly larger mortality declines in the higher SES groups, resulting in increasing inequalities in mortality associated with SES.

(G.K. Singh, M. Siahpush, Increasing inequalities in all-cause and cardiovascular mortality among US adults aged 25–64 by area socioeconomic status, 1969–1998, *International Journal of Epidemiology*, Vol. 31, pp. 600–613.)

- Among white men age 65 years, those with the highest income have a life expectancy three more years than those with the lowest income.
- Among people ages 25–64, the overall death rate for those with less than 12 years of education is more than twice that for people with 13 or more years of education.
- The level of education attained by women is a key determinant of the welfare and survival of their children. For instance, infant mortality is almost double for infants of mothers with less than 12 years of education compared with those with an educational level of 13 years or more.

Social Determinants of Health

An entire sub-field called social epidemiology now focuses on the health impact of social factors. More and more data show that the underlying conditions in which a person lives predict health to an equal or perhaps greater extent than access to medical care or lifestyle factors such as diet and tobacco use. The World Health Organization's 1986 Ottawa Charter includes the following prerequisites of health:

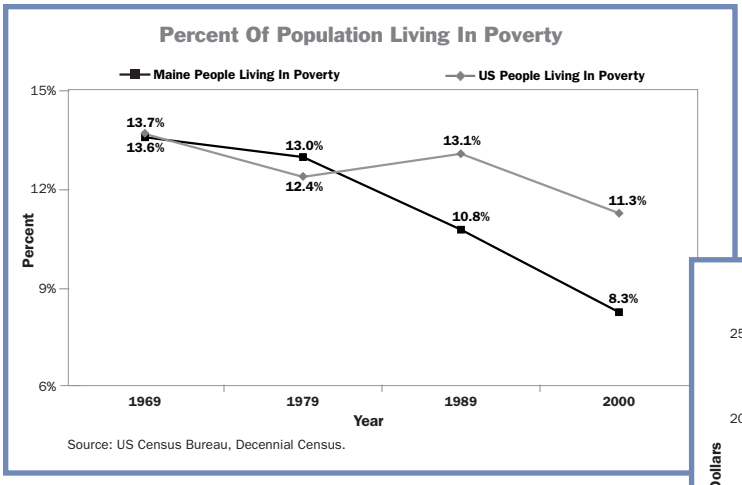
- **peace**
- **education**
- **income**
- **sustainable resources**
- **shelter**
- **food**
- **stable ecosystem**
- **social justice**
- **equity**

Social determinants of health predict a great proportion of variance in health status. Health Canada has defined the following key determinants of health:

- **income and social status**
- **social support networks**
- **education**
- **employment/working conditions**
- **social environments**
- **physical environments**
- **personal health practices and coping skills**
- **healthy child development**
- **biology and genetic endowment**
- **health services**
- **gender**
- **culture**

IN MAINE, WE KNOW:

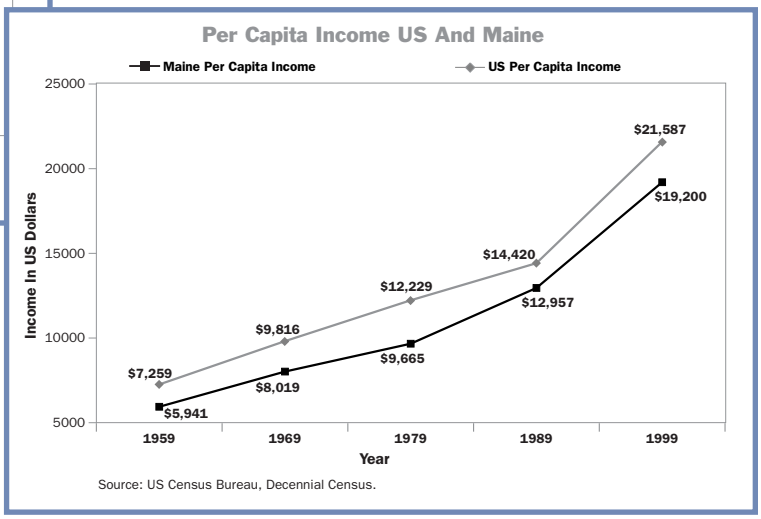
- Maine ranks 36th in the nation on personal income standings according to the 2002 Measures of Growth.
- Maine's estimated household income is $37,400, the lowest in New England and below the national average of $41,343.



Source: US Census Bureau, Decennial Census.

- According to the 2001 Measures of Growth, the wealthiest fifth of Maine families earn on average 8.5 times as much as the poorest fifth of Maine families, and 29% of Maine's population earns less than 200% of the Federal Poverty Level.

(Some Maine economic data sources: 2001 and 2002 Measures of Growth of the Maine Economic Growth Council prepared by the Maine Development Foundation)



Source: US Census Bureau, Decennial Census.

- Employment status is also associated with income and education. As an example of looking at employment status and its impact on health:
  Percent of Maine adults under age 65 who report they have diabetes:
  7.9% unemployed **3.3% employed**

CHALLENGES:

- We face challenges in defining socioeconomic status and its impact on health, since SES is much more than simply levels of income and education (see insert on social determinants of health). As research nationally and from other countries more clearly defines these determinants, it may become easier in the future to measure their impact on health here in Maine.
- Definitions for measuring income and education levels are less of an issue than other factors. However, income and education levels are not fully collected with all pertinent health data systems (see appendix). For instance, income is not collected with youth surveys (YRBS and MYDAUS), data systems that measure encounters with the health care system such as the MHDO data system, disease registries such as the Cancer Registry and Infectious Disease Reports, or with vital records. Sometimes analyses use the utilization of the health care delivery system by people with Medicaid Insurance as a proxy for measuring the impact of low income on health care utilization, but this has many limitations, including exclusion of people without health insurance.

- Education level is collected by youth surveys (YRBS and MYDAUS), but since education levels are not fully attained by respondents (by virtue of the fact they are in school at the time of the survey), this information is used primarily as a proxy for age – for instance, comparing 12th graders to 9th graders gives an idea of the differences between 18-year-olds and 14-year-olds.
- The impact socioeconomic status exerts on health overlaps with other factors. For instance, children, women, people with disabilities, racial and ethnic minorities are more likely to live in poverty. Therefore, one of our biggest challenges is to tease out the specific impacts SES has on health.
- Since socioeconomic status is considered by many to be the leading factor influencing our overall health, tracking its impact on the health of Mainers needs to be a priority. With improved measurements it will be easier to identify effective interventions that provide the opportunities for Maine people at all levels of socioeconomic status for longer and healthier lives.

Kevin Lewis, Executive Director
Maine Primary Care Association

"The health issues that we are most concerned about when reaching out to underserved populations are diabetes, depression, asthma, and cardiovascular disease. But we are challenged by our predominantly rural demographics in sustaining and expanding the care infrastructure. Our effort is to spread accessible and comprehensive models of primary care that most effectively address these chronic conditions."

Education Levels Among Maine People 25 Years and Older:

High School Education Attainment:

Eighty-nine percent (89%) have graduated from high school, compared with 84% nationally and 86% in New England. Maine's attainment is the second highest in New England, with Vermont at a 90% attainment level.

Bachelor's Degree Attainment:

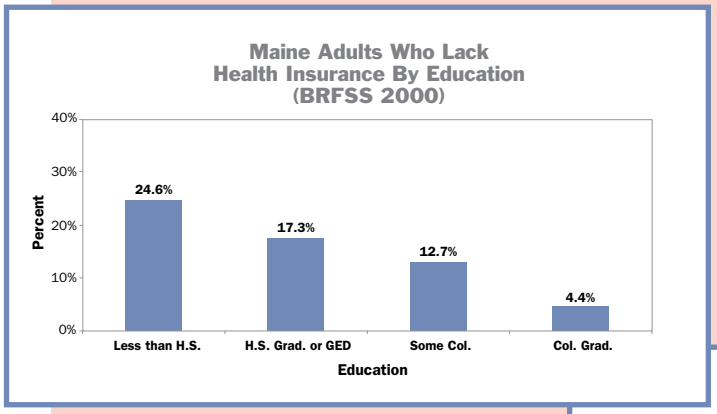
Twenty-four percent (24%) have a bachelor's degree or higher degree, compared with 26% nationally and 31% in New England. Maine's attainment level is the lowest in New England; Massachusetts has the highest at 35%.

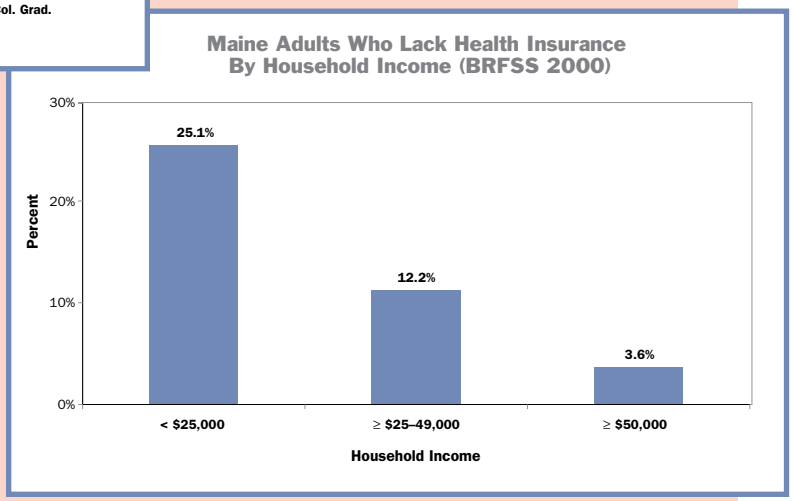
Graduate Degree Attainment:

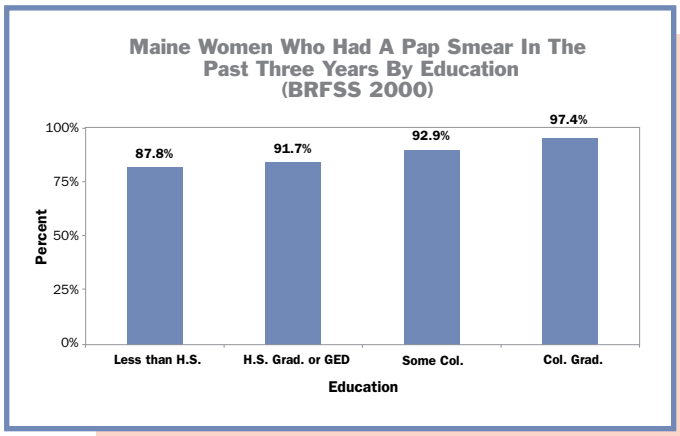
Five and three-tenths percent (5.3%) (preliminary estimate) have attained a graduate degree, compared with 5.6% nationally and 8.7% in New England.

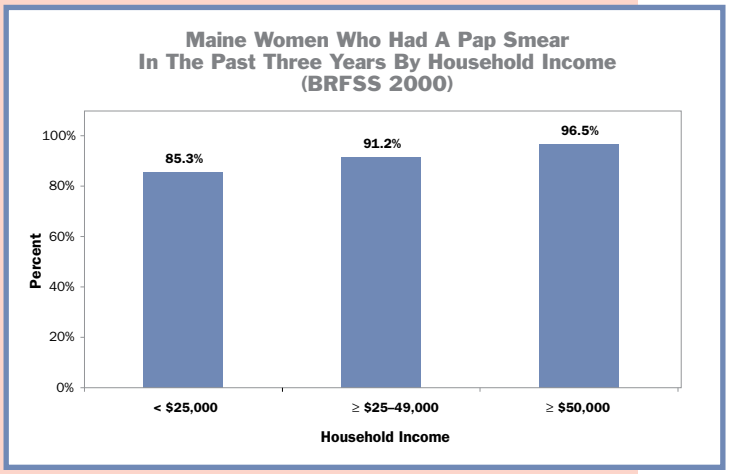
(Source: 2000 Census and the 2002 Measures of Growth)

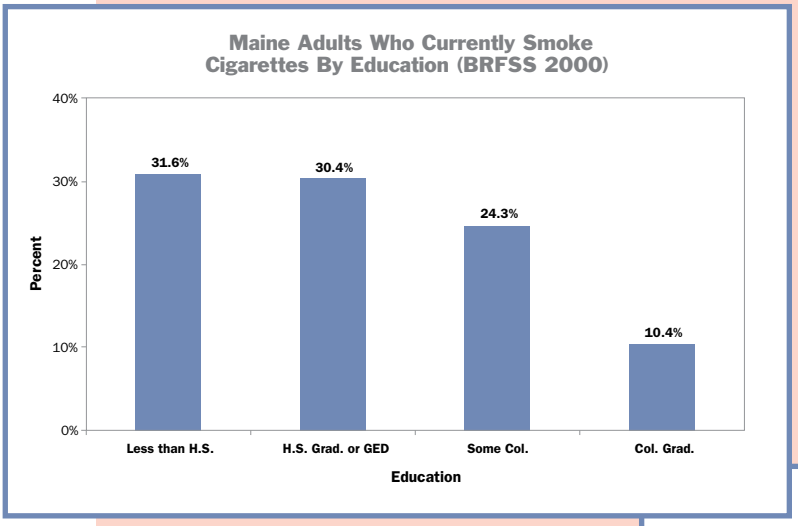
BOTH INCOME AND EDUCATION IN MAINE ARE ASSOCIATED WITH INCREASED HEALTH ACCESS AND PREVENTION:

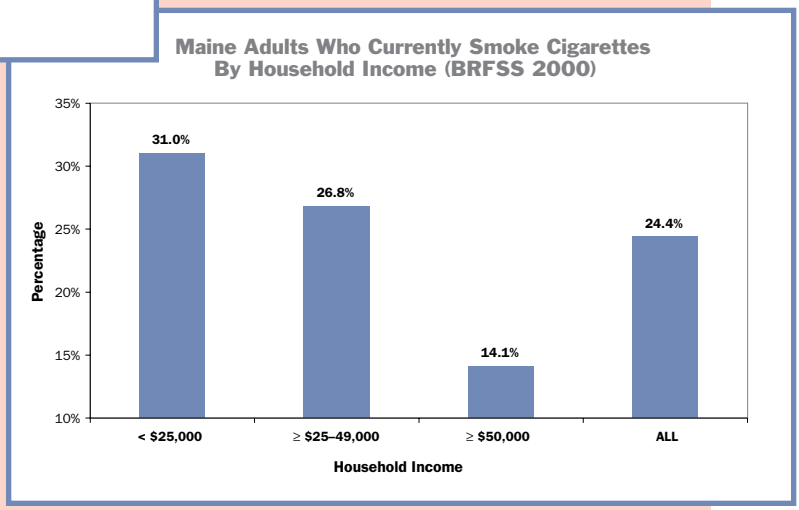


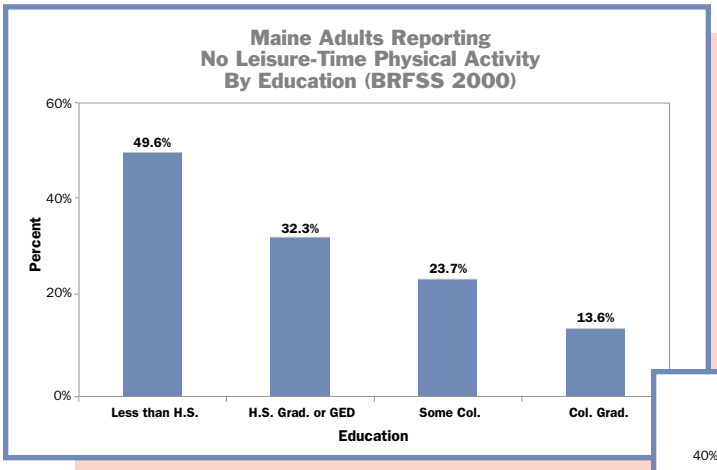


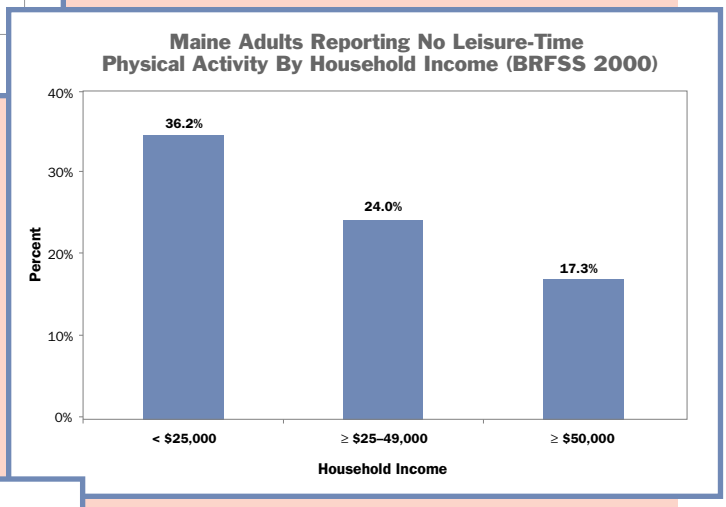

Maine Women Who Had A Pap Smear In The Past Three Years By Education (BRFSS 2000)
100%
75%
50%
25%
0%
Percent
87.8%
91.7%
92.9%
97.4%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

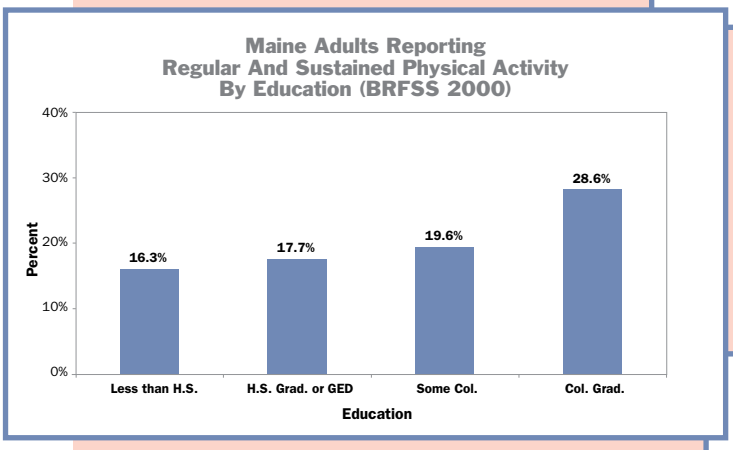

Maine Women Who Had A Pap Smear In The Past Three Years By Household Income (BRFSS 2000)
100%
80%
60%
40%
20%
0%
Percent
85.3%
91.2%
96.5%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

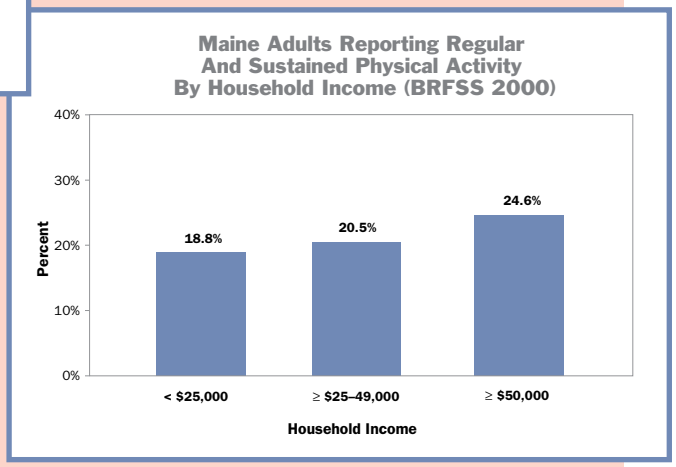

Maine Adults Who Currently Smoke Cigarettes By Education (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
31.6%
30.4%
24.3%
10.4%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

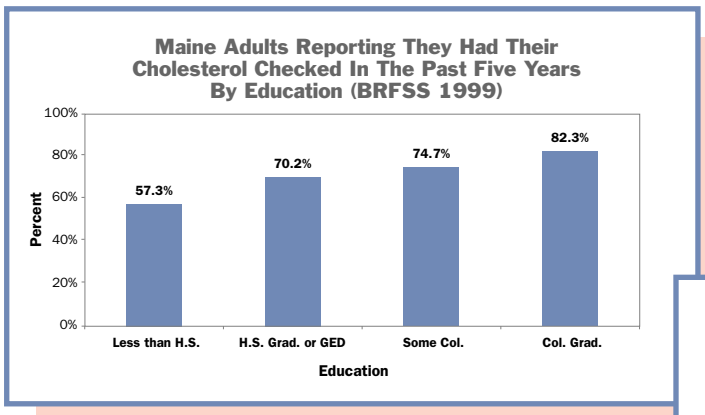

Maine Adults Who Currently Smoke Cigarettes By Household Income (BRFSS 2000)
35%
30%
25%
20%
15%
10%
Percentage
31.0%
26.8%
14.1%
24.4%
< $25,000
≥ $25–49,000
≥ $50,000
ALL
Household Income

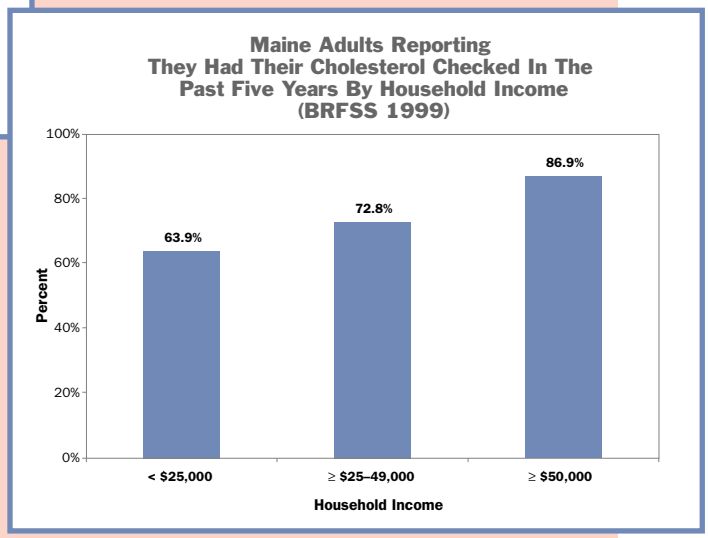

Maine Adults Reporting
No Leisure-Time Physical Activity
By Education (BRFSS 2000)
60%
40%
20%
0%
Percent
49.6%
32.3%
23.7%
13.6%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

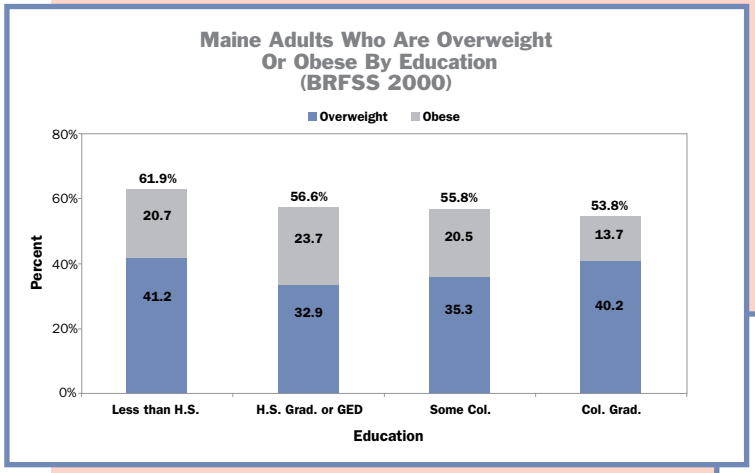

Maine Adults Reporting No Leisure-Time
Physical Activity By Household Income (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
36.2%
24.0%
17.3%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

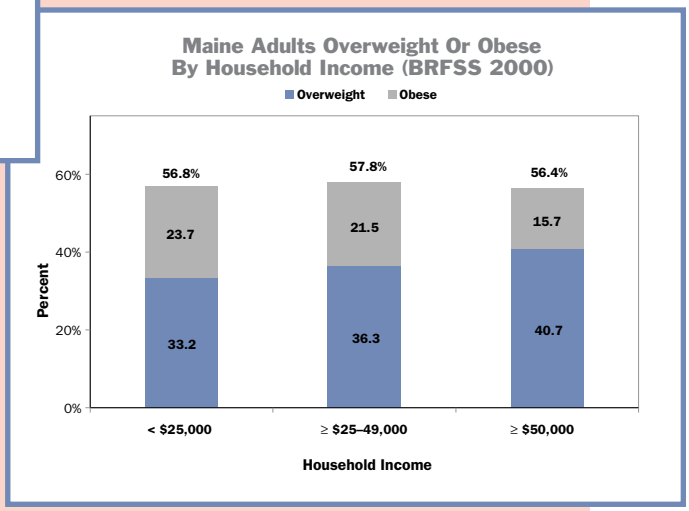

Maine Adults Reporting
Regular And Sustained Physical Activity
By Education (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
16.3%
17.7%
19.6%
28.6%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

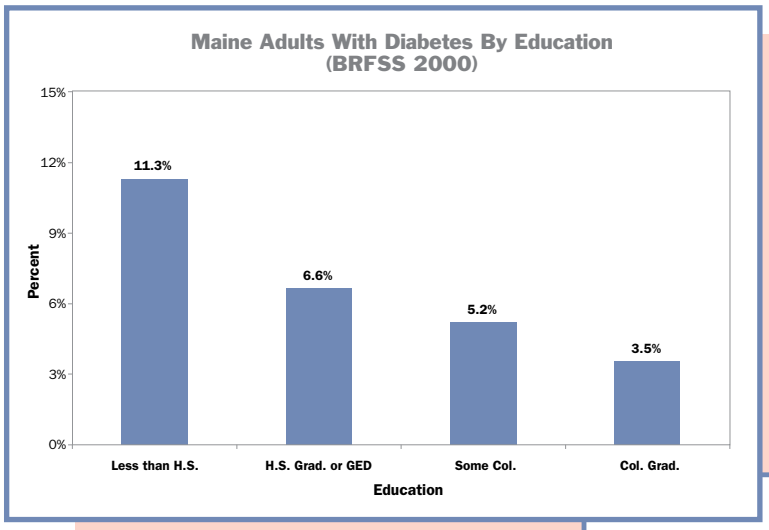

Maine Adults Reporting Regular
And Sustained Physical Activity
By Household Income (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
18.8%
20.5%
24.6%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

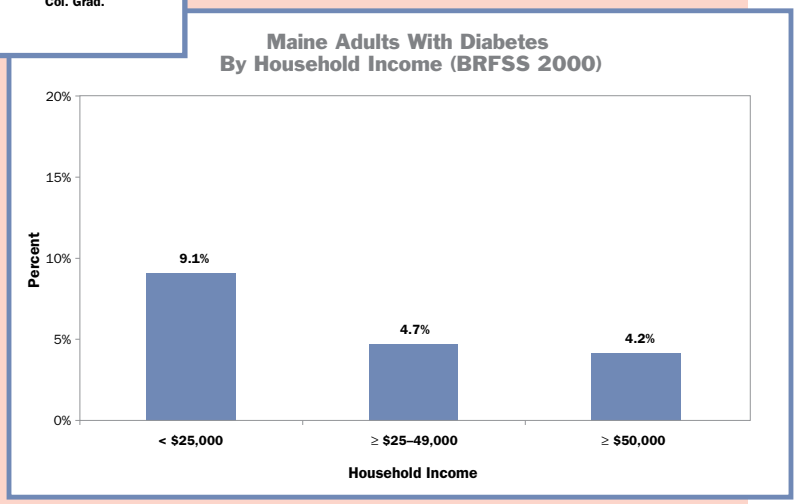

Maine Adults Reporting They Had Their Cholesterol Checked In The Past Five Years By Education (BRFSS 1999)
100%
80%
60%
40%
20%
0%
Percent
57.3%
70.2%
74.7%
82.3%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

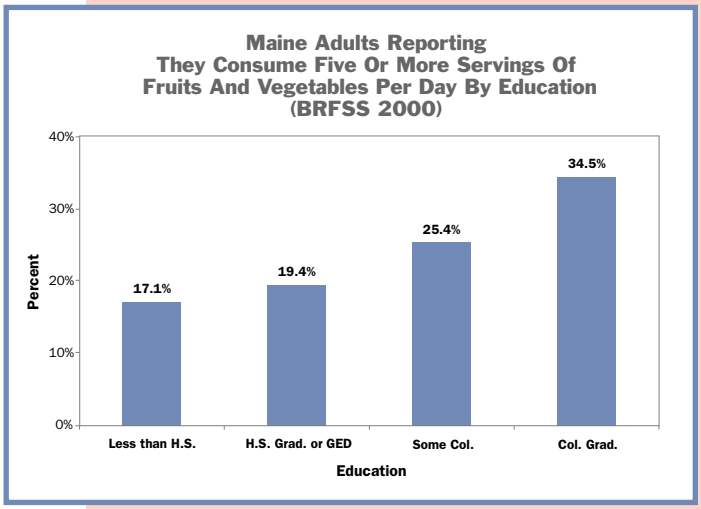

Maine Adults Reporting They Had Their Cholesterol Checked In The Past Five Years By Household Income (BRFSS 1999)
100%
80%
60%
40%
20%
0%
Percent
63.9%
72.8%
86.9%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

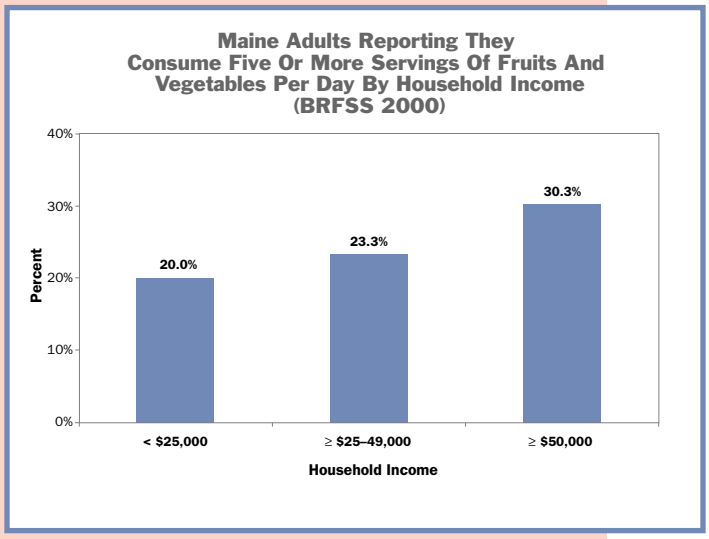

Maine Adults Who Are Overweight Or Obese By Education (BRFSS 2000)
Overweight
Obese
80%
60%
40%
20%
0%
Percent
61.9%
20.7
41.2
56.6%
23.7
32.9
55.8%
20.5
35.3
53.8%
13.7
40.2
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

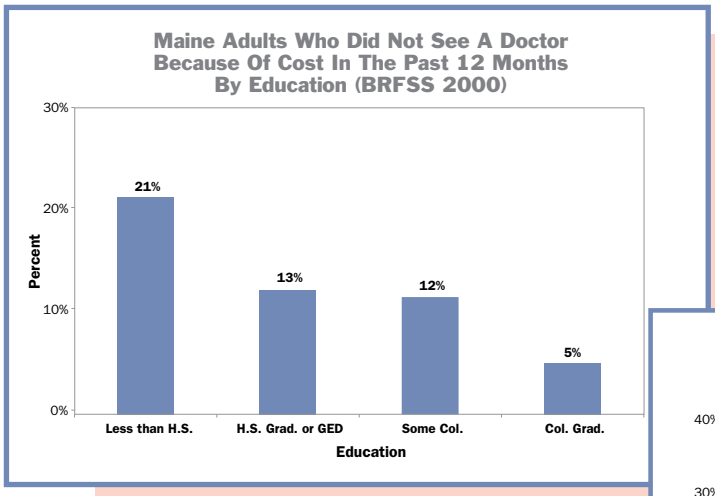

Maine Adults Overweight Or Obese By Household Income (BRFSS 2000)
Overweight
Obese
60%
40%
20%
0%
Percent
56.8%
23.7
33.2
57.8%
21.5
36.3
56.4%
15.7
40.7
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

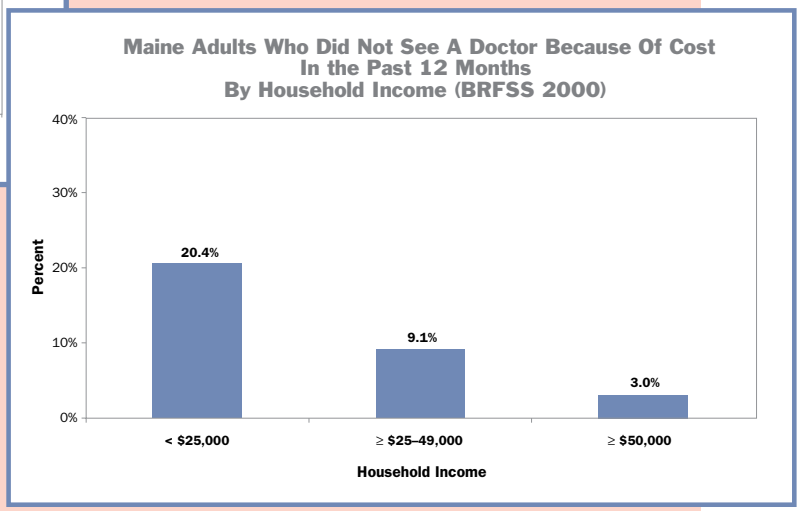

Maine Adults With Diabetes By Education (BRFSS 2000)
15%
12%
9%
6%
3%
0%
Percent
11.3%
6.6%
5.2%
3.5%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education

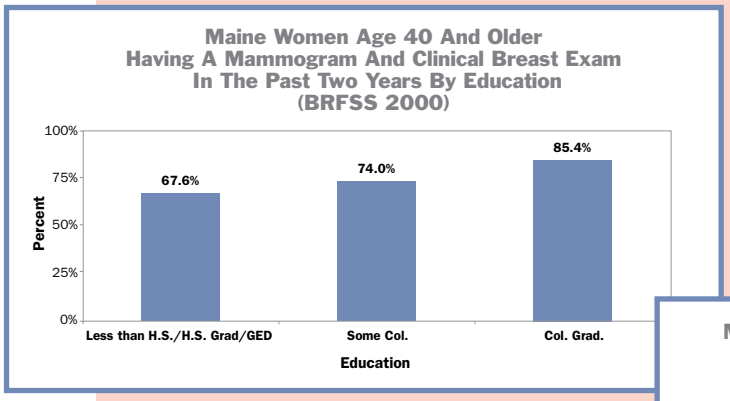

Maine Adults With Diabetes By Household Income (BRFSS 2000)
20%
15%
10%
5%
0%
Percent
9.1%
4.7%
4.2%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

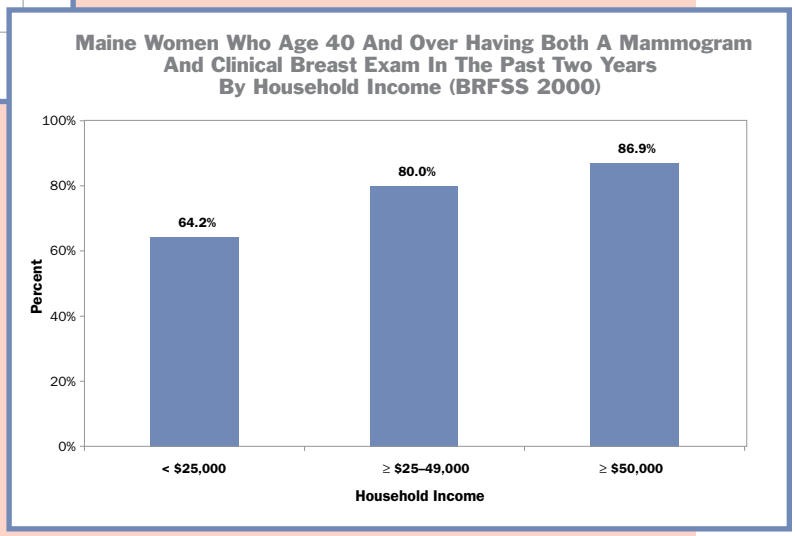

Maine Adults Reporting They Consume Five Or More Servings Of Fruits And Vegetables Per Day By Education (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
17.1%
19.4%
25.4%
34.5%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education


Maine Adults Reporting They Consume Five Or More Servings Of Fruits And Vegetables Per Day By Household Income (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
20.0%
23.3%
30.3%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income


Maine Adults Who Did Not See A Doctor
Because Of Cost In The Past 12 Months
By Education (BRFSS 2000)
30%
20%
10%
0%
Percent
21%
13%
12%
5%
Less than H.S.
H.S. Grad. or GED
Some Col.
Col. Grad.
Education


Maine Adults Who Did Not See A Doctor Because Of Cost
In the Past 12 Months
By Household Income (BRFSS 2000)
40%
30%
20%
10%
0%
Percent
20.4%
9.1%
3.0%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income


Maine Women Age 40 And Older
Having A Mammogram And Clinical Breast Exam
In The Past Two Years By Education
(BRFSS 2000)
100%
75%
50%
25%
0%
Percent
67.6%
74.0%
85.4%
Less than H.S./H.S. Grad/GED
Some Col.
Col. Grad.
Education


Maine Women Who Age 40 And Over Having Both A Mammogram
And Clinical Breast Exam In The Past Two Years
By Household Income (BRFSS 2000)
100%
80%
60%
40%
20%
0%
Percent
64.2%
80.0%
86.9%
< $25,000
≥ $25–49,000
≥ $50,000
Household Income

RACE AND ETHNICITY

NATIONALLY, WE KNOW:

- Biological and genetic differences do not explain the health disparities experienced by different racial and ethnic populations, especially since there is no biological basis for race. These disparities are felt to be the result of an interaction of mainly environmental factors and health behaviors.
- In March 2002, three important reports were published, all showing significant health disparities in both health status and quality of health care faced by racial and ethnic minorities in America; even when income, education attainment, and insurance status are controlled for: Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Commonwealth Fund's "Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans," and the American Medical Association report "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care."
- By 2030, 40% of Americans are expected to belong to a minority racial or ethnic group, compared with 28% today.

Foreign-Born Population Of US As A % Of Total Population:			
US:		**MAINE:**	
1850	9.7%		
1900	13–15%	**1902**	13.5%
1930	11.6%		
1950	6.9%		
1970	4.7%		
1980	6.2%		
1990	7.9%		
2000	11.1%	**2000**	2.9%

Sources: US Census Bureau and Bureau of Labor Statistics.

2000 Maine: One-third of the 2.9% foreign-born residents in 2000 had entered the US between 1990–2000. In 1902, three-quarters of Maine's foreign-born population were from Canada and Ireland.

Since 1980 across the US the biggest change has been an increase in immigration from Asia and Latin America.

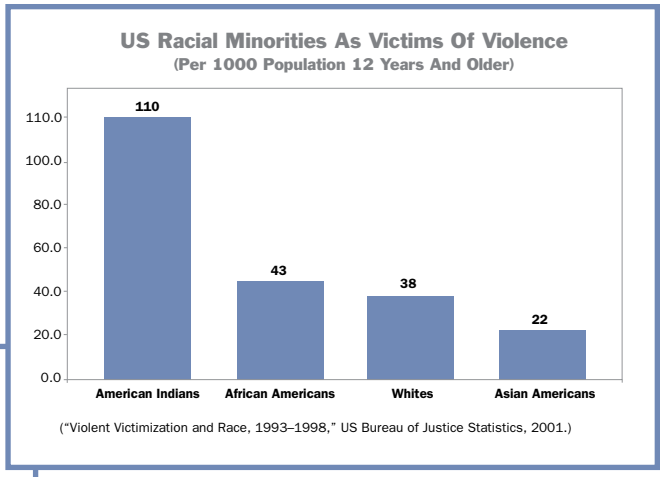
What are Race and Ethnicity?

Race is a *sociological* characteristic – generally thought of as a characteristic by which one is identified by others. Often these characteristics are related to skin color and/or facial features. Genetic studies have thoroughly discredited the concept of race as a biological characteristic (among them: Witzig, R. "The Medicalization of Race: Scientific Legitimization of a Flawed Social Construct." *Annals of Internal Medicine.* 1996; 125:675-679). Racial categories are often overlapping, and therefore, the 2000 Census allowed respondents to claim multiple racial identities for the first time.

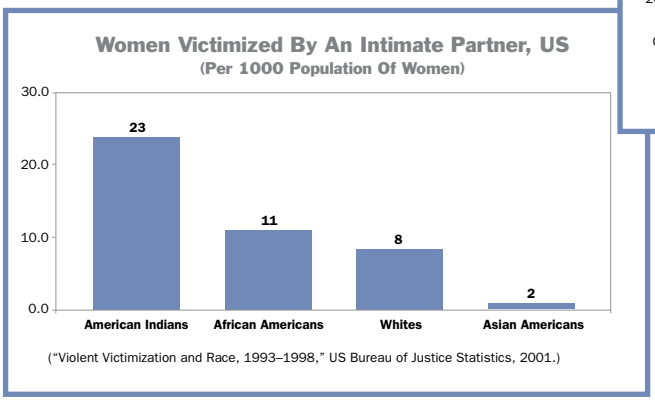
Ethnicity is often used synonymously with ancestry and includes concepts of culture, language, and national origin. Ethnic groups are often multiracial.

Category terms of race and ethnicity are becoming less valid, particularly as more Americans are of mixed ancestry and as biological concepts of race have been discredited. Some are replacing both these terms with "ethnic groups" or "minority population groups." However, even as the usefulness of racial and ethnic categories in some ways is diminishing, we are also more aware of the impact these social constructs have on health status. It appears that the reasons why these factors impact health include a number of possibilities, including differences in social class, culture, behavioral risk factors, psychosocial risk factors, and the direct effects of racism, segregation, and discrimination.
(Williams, DR, and C. Collins. "United States Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology.* 1995; 21:349-386.)

Some highlights of health disparities known nationally include:



("Violent Victimization and Race, 1993–1998," US Bureau of Justice Statistics, 2001.)



("Violent Victimization and Race, 1993–1998," US Bureau of Justice Statistics, 2001.)

African Americans experience:

- Infant mortality rates more than twice that of whites;
- Death rates from heart disease more than 40% higher that of whites;
- Death rates from cancers 30% higher than that of whites;
- Prostate cancer death rates more than twice that of whites;
- Higher death rates from breast cancer despite mammography rates being similar;
- Death rates from diabetes almost 30% higher than that of whites;
- Death rates from HIV/AIDS more than seven times that of whites;
- Death rates from homicide six times more than that of whites, making it either the leading or second leading cause of death for black males ages 1–44 years (leading cause in the 15–34-year-old age group);
- At birth, the average life expectancy for African Americans is 72 years compared to over 77 years for whites. Black males have the lowest life expectancy of all Americans: 68 years, compared with 75 years for white men. Life expectancy for black women is 75 years, compared with 80 years for white women.

Hispanics experience:

- Death rates from diabetes twice as high than non-Hispanic whites;
- Nearly twice the rate of tuberculosis than non-Hispanic whites;
- Higher rates of high blood pressure and obesity than non-Hispanic whites.

American Indians and Alaskan Natives experience:

- Infant mortality rates almost double than that of whites;
- Rates of diabetes more than twice that of whites;
- Higher death rates from unintentional injuries and suicide than whites;
- Suicide as the second leading cause of death for 15–24-year-olds, and for males in this age group, suicide rate is twice as high than for nonnative males in the same age group.

The US Department of Health and Human Services is focusing on six major areas in which racial and ethnic minorities experience serious disparities in health access outcomes: diabetes, heart disease and stroke, cancer, infant mortality, child and adult immunization, and HIV/AIDS.

Asians and Pacific Islanders experience:

- In general, some of the best health in the US, based on common health indicators;
- Cervical cancer rates in Vietnamese women nearly five times higher than rates for white women;
- Higher rates of hepatitis and tuberculosis than rates for whites.

Definitions of Terms Commonly Used with Foreign-Born Populations

Refugees: Persons who flee their country due to a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. They are eligible for some Federal assistance programs and to work in this country upon arrival, as well as for permanent residency after one year.

In Maine, Portland is a Refugee Resettlement Center, funded primarily by the US Federal Government. Initial reception and placement services are provided by Catholic Charities of Maine.

Countries of origin of predominant refugee groups and numbers resettled in Maine from 1982–1998:

Cambodia	646	Vietnam	571
Poland	387	Afghanistan	352
Former Soviet Union	349	Bosnia Herzogovina	283
Somalia	247	Sudan	172
Iran	133	Ethiopia	125

These figures do NOT include secondary migration of refugees who first settled in other parts of the country. Secondary migration has tripled since 1997 to over 700 per year.

Asylees: Refugees who are already present in the US at the time they apply for refugee status. They are eligible for the same benefits as refugees, but only 10,000 may become permanent residents each year in the US.

Parolees: People who would not normally be admissible but are allowed to enter temporarily for humanitarian, legal, or medical reasons. They are not eligible for Federal benefits or predestined permanent residency status, except for some Cubans and Haitians.

Illegal Aliens: Also known as undocumented immigrants, persons who enter or live in the US without official authorization.

Immigrants: Legal immigrants are admitted to the US based on family relation or job. Since 1988, about 8,400 legal immigrants have moved to Maine, with Canada the most common country of origin.

Migrant Workers: People who move to different geographical regions on a seasonal basis according to job availability. Different government agencies define migrant workers in a variety of ways. Maine has a number of migrant workers, many of whom are Hispanic or Southeast Asian, who are employed in the planting, harvesting, and production of potatoes, blueberries, apples, broccoli, eggs, wreaths, seafood, and trees. Seasonal farmworkers are those who work in farming on a seasonal basis, but do not move from their home base.

(Sources: information from Meryl Troop at Maine Department of Behavioral and Developmental Services; and *Healthy People 2010*, Department of Health and Human Services.)

IN MAINE, WE KNOW:

Maine's population is predominantly white and has a smaller proportion of racial minority populations compared with the nation.

Populations By Race/Maine And US

	White	Black	Native American	Asian	Native Hawaiian Or Other Pacific Islanders	Other	Two Or More Races
Maine Numbers, 2000	1,236,014	6,760	7,098	9,111	382	2,911	12,647
ME 1990	98.4%	0.4%	0.5%	0.5%	<0.1%	0.1%	NA
ME 2000	96.9%	0.5%	0.6%	0.7%	<0.1%	0.2%	1.0%
US 2000	75.1%	12.3%	3.6%	3.6%	0.1%	5.5%	2.4%

Source: Census, 2000 and 1990.

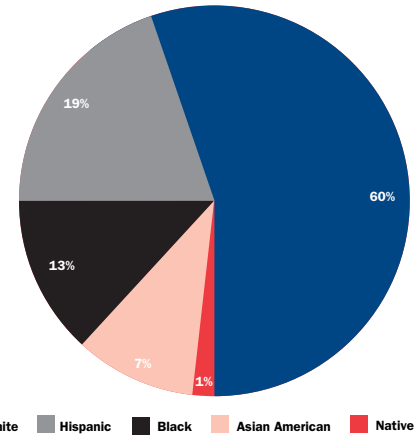
Population By Race – Alone Or In Combination With One Or More Races

	White	Black	Native American	Asian	Native Hawaiian Or Other Pacific Islanders	Other	Two Or More Races
Maine Numbers 2000 Census	1,247,776	9,553	13,156	11,827	792	5,227	NA
Percentage	97.9%	0.7%	1.0%	0.9%	0.1%	0.4%	NA

Source: Census, 2000.

- According to the 2000 Census, nearly 90,000 Maine people over age five are estimated to speak a language other than English at home.
- Of those, approximately 18,000 speak English less than "very well."
- Of the estimated 38,600 foreign-born Maine residents, 25%, or one in four, of them were born in Asia (Census, 2000).
- Of the estimated 38,600 foreign-born Maine residents, 31%, or about one in three, of them entered the US between 1990 and 2000.
- Ethnic and racial minority populations vary by region in Maine. For instance, black and Asian populations tend to account for the biggest proportion of racial minority populations in the southern counties of Cumberland, York, and Androscoggin. Native Americans tend to account for the biggest proportion of the racial minority populations in the northern counties of Washington, Penobscot, Aroostook, and Piscataquis. In fact, Washington County has the highest percentage of racial minorities in Maine with 4.4% of its population identifying themselves as Native American in the 2000 Census. Ninety-three percent (93%) of Washington County is white, compared to a statewide average of 96.9% (Cumberland County is 95.7% white).

Projected Resident Population Of The US 2030



Source: Current Population Reports, Series P25-1130, U.S. Bureau of the Census, 1996.

Federal Definitions of Racial and Ethnic Categories

RACIAL CATEGORIES:

American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

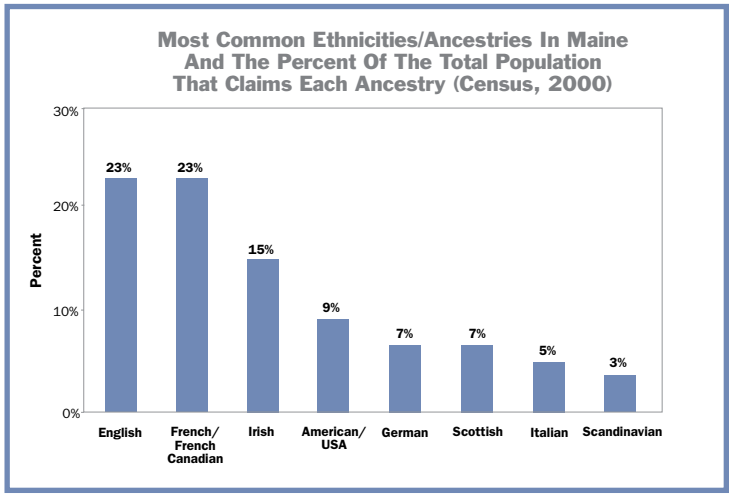
ETHNIC CATEGORIES:

Hispanic or Latino: A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.

- About two-fifths (41% in 2000 and 44% in 2001) of Maine youth interviewed stated that people who know them would perceive them to know a lot about people of other races (Maine Marks 2000 and 2001 survey, Department of Education).
- About three-quarters (76% in 2000 and 73% in 2001) of Maine youth interviewed stated that people who know them would perceive them to enjoy being with people who are of a different race than themselves (Maine Marks 2000 and 2001 survey, Department of Education).
- A genetic condition called hypercholesterolemia has been found in some Franco-American families in Maine. These families share an LDL-receptor defect, resulting in dangerously high levels of LDL cholesterol. Early detection through cholesterol testing of children and young adults followed by drug treatment is a first step in preventing heart disease in this group.

The Philippine Association of Maine Dancers at the Blaine House Summit on a Healthy Maine.

- Some preliminary health assessments done by the Bureau of Health indicate health disparities among Maine's Native American and Latino populations (see inserts). It is hoped that similar assessments can be done on Maine's other minority populations. Since Maine's black and Asian communities are perceived to be quite diverse culturally and socioeconomically, it is probable that some of the same challenges in measuring their health status may be similar, as seen in the Latino health assessment.
- Since French ancestry is rarely asked in Maine's health data sets, it is important that asking this ethnicity be implemented.



CHALLENGES

- Preliminary health assessments of Native Americans and Latinos in Maine both reveal the same three sets of challenges we face in measuring the health status of other racial and ethnic minorities in Maine: challenges regarding definitions, measurement strategies, and quality assurance.

Challenges in Definitions:

- We in Maine face challenges in defining race and ethnicity. As the health data matrix in the appendix and accompanying text show, race and ethnicity can usually be found in our health data sets, but there is currently great variability in how race and ethnicity are asked and reported.
- In 1997, the Federal Office of Management and Budget asked for revisions on how race and ethnicity should be asked by any State agency receiving Federal funds (OMB Directive Number 15):
  - There will be five minimum categories for data on race: American Indian or Alaskan Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, and white. Respondents are asked to mark one or more racial categories.
  - There will be at least two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino."
- Very few health data systems obtain ethnic background other than Hispanic ancestry, yet we know from Census data that 23% of Maine people have some French/French-Canadian ancestry. We therefore continue to face challenges in measuring the health status of this population.
- Bureau of Health data systems are in the process of standardizing the way they ask race and ethnicity. Most likely, this will be identical to the Federal standard, with the exception of adding a Franco-American option to the ethnicity questions.

Challenges in Measurement Strategies:

- Because most of Maine's racial and ethnic minority populations represent a smaller proportion of the overall population relative to other states, alternative methodologies need to be developed and implemented to measure the impact of race and ethnicity on health. This is important because national health data and even the limited data in Maine show that racial and ethnic minorities face health disparities. If our health data in Maine do not accurately reflect the health status of all Maine people, including racial and ethnic minorities, our health resources will not be used effectively and, as a result, all Maine people will not have the opportunity to live longer and healthier lives.
- Three common alternatives exist for collecting or analyzing data for minority populations:
  - One can use statewide sample techniques and over sample in areas with sizable populations of the minority group of interest;
  - One can directly survey the major minority populations in the areas where they dominate; or
  - One can analyze multi-year groupings of survey results for a minority population and examine trends (such as looking at five-year moving averages).

  The first two methods significantly increase the cost and size of a survey, but if Maine identifies a preferred method to be used, then the process is easier to implement if additional resources are identified.

Geographic Area	Total Population	RACE							ETHNICITY
		White	Black Or African American	American Indian And Alaskan Native	Asian	Native Hawaiian And Other Pacific Islander	Some Other Race	Two Or More Races	Hispanic Or Latino (Of Any Race)
MAINE	**1,274,923**	**1,236,014**	**6,760**	**7,098**	**9,111**	**382**	**2,911**	**12,647**	**9,360**
COUNTY									
Androscoggin	103,793	100,658	683	282	572	40	294	1,264	988
Aroostook	73,938	71,572	281	1,005	351	19	122	588	441
Cumberland	265,612	254,291	2,815	763	3,707	99	923	3,014	2,526
Franklin	29,467	28,865	72	109	126	6	49	240	159
Hancock	51,791	50,554	130	193	196	18	105	595	336
Kennebec	117,114	114,129	404	469	690	24	206	1,192	852
Knox	39,618	38,935	94	87	141	4	49	308	225
Lincoln	33,616	33,099	57	88	124	8	34	206	155
Oxford	54,755	53,797	95	151	201	12	59	440	292
Penobscot	144,919	139,989	708	1,444	1,019	47	328	1,384	882
Piscataquis	17,235	16,862	36	89	47	4	24	173	89
Sagadahoc	35,214	33,977	323	110	222	22	133	427	391
Somerset	50,888	49,868	121	208	171	11	55	454	234
Waldo	36,280	35,513	68	144	76	5	57	417	215
Washington	33,941	31,728	88	1,505	101	4	151	364	274
York	186,742	182,177	785	451	1,367	59	322	1,581	1,301

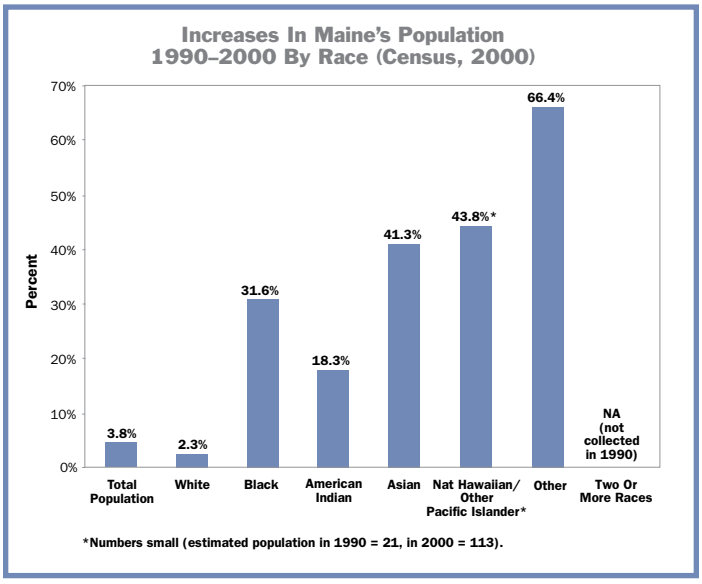
Source: US Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Matrices PL1 and PL2.

- The 2000 Census was the first to use the category of "two or more races." Interestingly, this category accounts for the largest numbers of Maine people in a racial category. However, when one examines the racial categories specified by those who designate themselves as two or more races and add those to the single race categories, Native Americans become the most prevalent racial minority in Maine.
- Many people feel the Census undercounts racial and ethnic populations. Some of the reasons include that some racial minorities may have been concerned about being counted in the Census.

Challenges in Quality Assurance:

- It is important that the Bureau of Health works to improve quality assurance of its vital statistics with regards to the racial and ethnic minority population statistics it collects. Nationally, it is known that vital statistics (death, birth, abortion, marriage, and divorce records) can lead to both overcounts and undercounts of minority populations' disease rates.

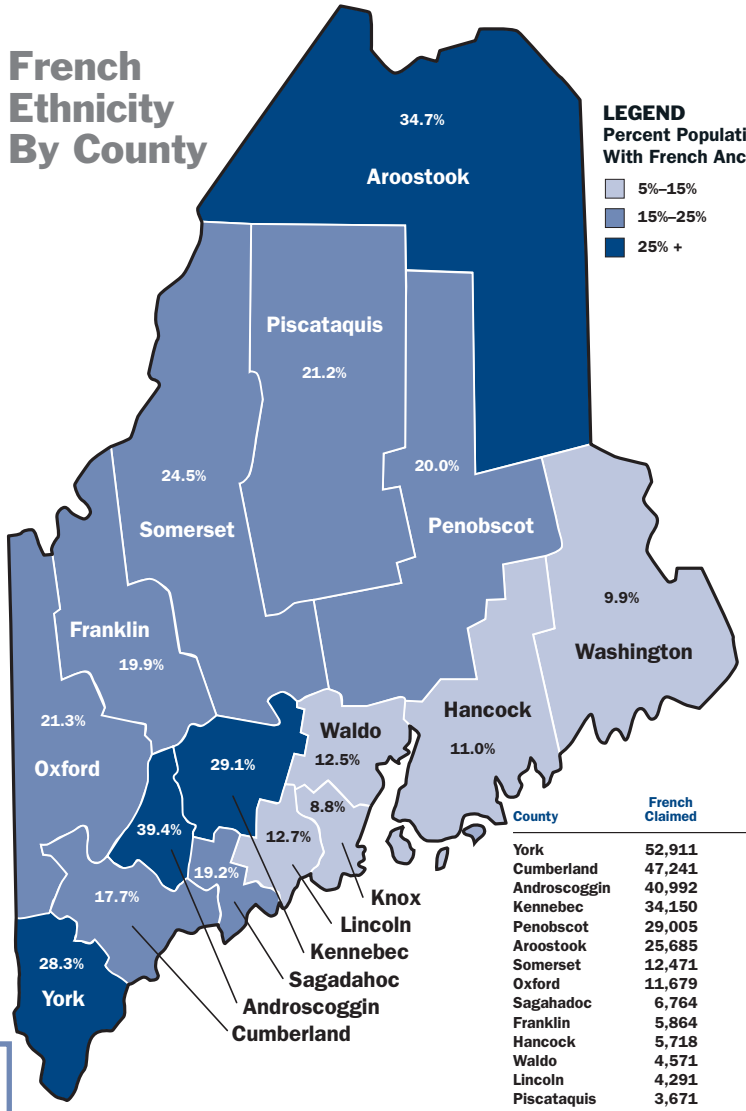
  For instance, Native Americans and other minorities, particularly in urban areas, are often undercounted. This can lead to an overestimation of mortality rates because the population base (denominator) used to determine these rates is reported to be smaller than it is.



On the other hand, minorities can also be misidentified. There is some evidence that may be happening here in Maine, at least among Native Americans and Latinos (see pertinent sections in this chapter). This can lead to underestimates of disease rates, since the numbers of people with a certain disease (the numerator in disease rates) is lower than what is real.

The Bureau is committed to start evaluating the reliability of its vital records regarding ethnicity and race as well as taking steps, resources permitting, to improve the quality assurance of its vital records and other health data sets.

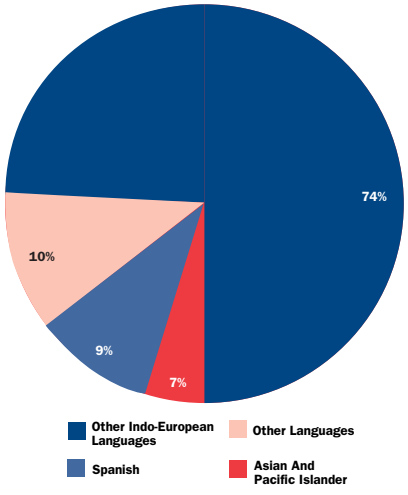
French Ethnicity By County



County	French Claimed	Total Population
York	52,911	186,742
Cumberland	47,241	265,612
Androscoggin	40,992	103,793
Kennebec	34,150	117,114
Penobscot	29,005	144,919
Aroostook	25,685	73,938
Somerset	12,471	50,888
Oxford	11,679	54,755
Sagahadoc	6,764	35,214
Franklin	5,864	29,467
Hancock	5,718	51,791
Waldo	4,571	36,280
Lincoln	4,291	33,616
Piscataquis	3,671	17,235
Knox	3,524	39,618
Washington	3,383	33,941

Source: Census 2000.

Languages Spoken At Home By Maine People Who Speak A Language Other Than English At Home (Census, 2000)



MIGRANT AND SEASONAL FARMWORKERS IN MAINE

Definitions

Different government agencies that serve farmworkers, such as US Departments of Health and Human Services, Labor, Education, and Agriculture, have different definitions for migrant and seasonal farmworkers. For instance, some do not include those who work in tobacco, cotton fields, plant nurseries, fishing, poultry, meatpacking, cattle, or forestry industries.

Migrant workers are often not counted by such data systems as the Census and various health surveys, so these data are unreliable when applied to migrant farmworkers. Therefore, service data, such as clinic data, are often used to characterize health issues farmworkers face.

There are an estimated 5,225 migrant farmworkers on an annual basis in Maine. There are also some children and other dependents, not working on the harvest, who accompany the migrant farmworkers. There are also about 15,000 seasonal farmworkers in Maine. Migrant and seasonal farmworkers are most commonly found in the blueberry, apple, broccoli, egg, and forestry industries.

Blueberry Harvest:

Maine produces more wild blueberries than any other state. In Washington, Hancock, and Waldo counties there are about 10,000–12,000 farmworkers employed for the blueberry harvest; the vast majority being migrant and seasonal workers. Of the migrant workers employed for this harvest, many of them are Hispanic, from southern Texas, Mexico, Puerto Rico, and Central America. The Hispanic migrant workers usually come to Maine as a family unit of 1–14 members. Additionally, many of the farmworkers for this harvest are historically and currently MicMac Indians from the Canadian Maritime Provinces.

Apple Harvest:

Apples are harvested in late August through October in Androscoggin, Cumberland, Kennebec, and Oxford counties, using a workforce that is predominantly single adult males from Jamaica through the Federal H-2A Program. It is estimated that at least 700 migrant or seasonal farmworkers are employed to harvest apples in Maine each year.

Broccoli Harvest:

Approximately 350–500 workers are hired each season (July–October) to harvest about 3,000 acres of broccoli in the Presque Isle and Caribou areas of Aroostook County. These are primarily Hispanic and Philippino workers from California and Texas, many of whom travel with their families and return to work Maine's broccoli harvest every year. However, this workforce is down in numbers for 2002 from previous years because of economic difficulties among some broccoli growers.

Egg Industry:

An estimated 300 seasonal or migrant farmworkers, many of whom are Hispanic, are employed in the egg industry, primarily in Androscoggin County.

Forestry:

Hispanic workers from Central America, who also work in the Southwestern US, are employed during the summer and fall in the forestry industry to plant and thin trees, particularly in Somerset, Franklin, Aroostook, and Piscataquis Counties.

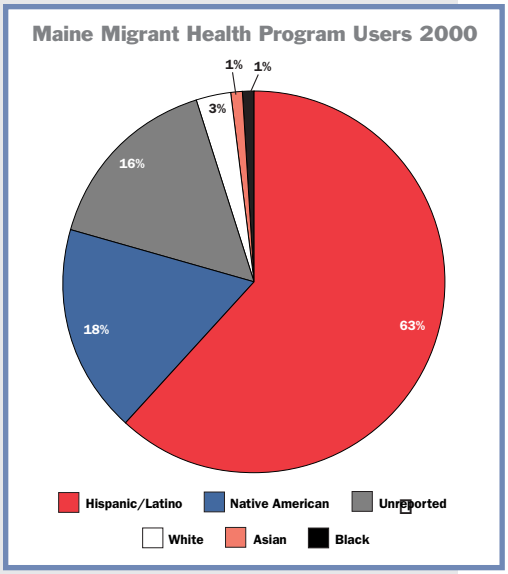
How much do migrant workers earn?

Many migrant workers in Maine, about 550 annually, are H-2A workers who are temporary foreign workers overseen by the US Department of Labor. Their wage must be the prevailing wage, the employers' wage offer, or $7.68 per hour, whichever is higher. Housing must be provided for free by the employer. Nine out of ten Migrant Health Program users in Maine in 1999 earned below the Federal poverty level (below $739 monthly income for a family of one; below $1,509 for a family of four).

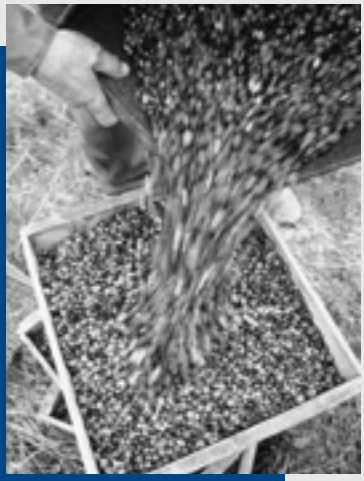
What about the health status of migrant and seasonal farmworkers?

Cultural, language, lifestyle, and general economic barriers cause migrant and seasonal farmworkers to have difficulty accessing services. For instance, many services are only available during business hours, yet migrants often do not want to or cannot leave work (their income source) during those hours to access services. Although many farmworkers may qualify for benefits such as Medicaid, eligibility varies from state to state, and there is no portability of eligibility. Additionally, most migrant workers have few connections to the local community and may live in social isolation.

Available national statistics show that migrant and seasonal farmworkers are at greater health risk, and their health status is substandard compared to other American workers. For instance, nationally, infant mortality is 25% higher than the national average and one study showed that poor health status is three times more common among migrant children.



What about race and ethnic backgrounds of Maine's migrant and seasonal farmworkers?



"How often do we look at a plateful of fruits and vegetables and think about the people who harvest our food? Migrant workers are particularly invisible – they are not counted in most of our health statistics; they are not seen in many of our stores, schools, and neighborhoods, and yes, they are not even thought of very often. But they live and work here among us."

Barbara Ginley, Director, Maine Migrant Health Program

What are some Maine programs that address specific health issues migrants face?

The Maine Migrant Health Program provides health services through a mobile health unit, nurse outreach services, and school-based services at the Rakers' Centers in the blueberry harvest camps, Maine Migrant Education Program's two Harvest Schools (one for blueberry rakers in Washington County and one for broccoli workers in Caribou), and the two Migrant Head Start sites (one in Harrington for blueberry rakers and one in Caribou for broccoli workers). Additionally, Maine's rural health centers and hospitals often provide services to migrant and seasonal farmworkers. Public Health Nurses from the Maine Department of Human Services' Bureau of Health provide direct nursing services, such as home visits to families with or expecting young children, and tuberculosis testing, and outreach.

(Data from Maine Migrant Health Program, Augusta, ME)

Maine's Hispanic/Latino Population

How Many Hispanics Live in Maine?

2000 Census	Population count was 9,360, or 0.7% of the population
1990 Census	Population count was 6,829, or 0.6% of the population
An increase of 37% from 1990 to 2000	

Maine's Hispanic/Latino Population Ancestry	
Total Hispanic/Latino	9,360
Mexican	2,756
Puerto Rican	2,275
Cuban	478
Other	3,851

Source: Census 2000

Many feel Maine's Hispanic population is actually much higher in 2000 because of possible undercounting by the Census.

About 40% of Maine's Latino population resides in Cumberland and York counties. One percent of the populations of Cumberland and Androscoggin counties are Latino.

A recent Bureau of Health review of some health data regarding Maine's Latino population (Paul Kuehnert, RN, MS, and Ruby Spicer, MPH, RN, "Health Status and Needs Assessment of Latinos in Maine," Maine Bureau of Health, June 2002) poses some paradoxes. While clinic data from the Maine Migrant Health Program clearly indicate Latino seasonal and migrant farmworkers are at a socioeconomic and health disadvantage, analysis of data that is primarily focused on non-migrant Maine Latino populations paints a different picture.

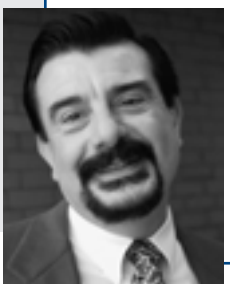
For instance, some Census, BRFSS, Vital Statistics, and PRAMS data suggest higher rates of health risks among Maine Latinos (physical inactivity, obesity, hypertension), while mortality data suggest lower rates of age-adjusted death rates from chronic disease. Likewise, other data suggest poor health status (shorter life expectancy, higher rates of domestic violence during pregnancy), while other data suggest the opposite (low infant mortality rates, higher rates of mammogram screening).

Socioeconomic data also suggest some paradoxes. Some data suggest Latinos in Maine are at a socioeconomic disadvantage (per capita income and education attainment from Census data, and PRAMS data identifying child care, transportation, and lack of insurance as barriers to care). Other data suggest Maine Latinos are similar to other Mainers (low unemployment levels and BRFSS data showing similar levels of income and health insurance).

It appears these paradoxes may be due to multiple factors, including:

- Possible undercounting by the Census and other surveys;
- Possible inaccuracies and misclassifications in the collection of ethnicity in health data sets, including death and birth certificates;
- Statistical analyses problems such as widely variant outcomes commonly encountered when working with small sample sizes;
- Additionally, key informants tell us that Maine's Latino population is diverse culturally and socioeconomically. This diversity may also be reflected in our inability to make accurate broad characterizations of this population.

Juan A. Perez-Febles, Director of the Division of Migrant and Immigrant Services for the Maine Department of Labor



"Finding affordable and accessible health care is a critical issue to members of Maine's Hispanic migrant worker population."

"Another challenge is acknowledging that we do have a large Hispanic population in this State. Health care providers have an opportunity to get to know this diverse population, which would enrich their lives culturally and professionally."

Native Americans in Maine

Barry L. Dana, chief of the Penobscot Indian Nation, drumming and singing.

Penobscot, Passamaquoddy, Maliseet, and Micmac people make up most of the over 7,000 Native American people in Maine.* They are all part of the Wabanaki group of tribes found in Maine and Eastern Canada. The vast majority of Native Americans live in or near five small rural communities of Indian Island (Penobscot Nation), Pleasant Point (Passamaquoddy tribe), Indian Township (Passamaquoddy tribe), Houlton (Houlton Band of Maliseet), and Presque Isle (Aroostook Band of Micmac). With the exception of Presque Isle, each of these communities includes a reservation or defined land where many tribal members live.

The Indian Health Service (IHS) funds health care services provided or purchased by the tribes. Although IHS reports it serves about 60% of American Indians and Alaskan Natives, services in urban areas and in non-reservation rural areas are very limited.

Each of Maine's tribes receives funding from IHS, the level determined by the number of tribal members. According to tribal health directors, this funding has been essentially flat. It also must be used for both prevention initiatives and direct health services. Therefore, funding for prevention is vulnerable to sudden increases in health care costs, such as a severe illness in one or several tribal members. According to the tribal health directors, about half to two-thirds of Native Americans in Maine live off reservation, and many of these live outside the service area for the IHS centers.

Indian Health Services provides some funds for five health centers in Maine: Penobscot Nation Health Department, Maliseet Health Center, Micmac Health Center, Pleasant Point Health Center, and Indian Township Health Center.

Some health data indicate Native American people in Maine compared to all of Maine's population:

- Are younger;
- Have lower per capita and household incomes;
- Experience higher rates of unemployment;
- Attain higher education at lower rates;
- Have higher birth rates, including teen birth rates;
- Die at a younger age (on average 60-years-old versus 74 for all Mainers);
- May die at higher rates from cancer, particularly lung cancer; and
- Experience higher rates of tobacco addiction, problem alcohol use, and overweight.

(Sources: Census; Maine Bureau of Health Office of Data, Research, and Vital Statistics; Micmac 1998 Behavioral Risk Factor Survey.)

* The terms "Native American" and "American Indian" are used interchangeably in this text. "American Indian" is used by the Federal government as a racial classification, and "Native American" is used by many other sources.

According to a report by the American Indian Health Care Association, although American Indians are culturally very diverse, they generally share the following experiences historically, all of which impact their health:

- **Rapid and forced change from a cooperative, clan-based society to a capitalistic and nuclear family-based system;**
- **Outlawing of language and spiritual practices;**
- **Death of generations of elders to infectious diseases or war; and**
- **Loss of the ability to use the land walked on by their ancestors for thousands of years.**

(Scott S., and M. Suagee. *Enhancing health statistics for American Indian and Alaskan Native communities: an agenda for action – A report to the National Center for Health Statistics.* St. Paul, MN: American Indian Health Care Association, 1992.)

Barriers to health identified by Maine's tribal health directors include:

- Transportation;
- Low income;
- Prejudice and racism;
- Shortages of qualified health personnel;
- Inadequate State and Federal funding;
- Lack of accessible and/or culturally appropriate health care, especially for substance abuse treatment and nursing home care;
- Threats from environmental toxins such as dioxin, mercury, lead, arsenic, and cadmium; and
- Inequitable public policy such as a result of no voting representation to the Maine Legislature.

(Source: Paul Kuehnert, MS, RN, "Health Status and Needs Assessment of Native Americans in Maine," Maine Bureau of Health, January 2000; and a July 2002 Native American Health Assessment report by the Wabanaki Mental Health Association to the Bureau of Health.)

Factors that may be hindering adequate health assessment of Maine's Native American population include factors in common with other racial and ethnic minority populations:

- Undercounting by the Census and other surveys;
- Inaccuracies and misclassifications in the collection of race in health data, including death and birth certificates; and
- Statistical analyses problems such as widely variant outcomes commonly encountered when working with small sample sizes.

An evaluation is underway by the Maine DHS Bureau of Health and Maine's tribal health directors to assess the accuracy of death certificate information. Studies elsewhere have shown Native Americans to be misclassified on death certificates, yielding low estimates for some diseases. One study found evidence of American Indian heritage being misclassified, and as a result under-reported by 65% on death certificates, leading to low estimates of deaths due to diabetes (Rousseau, P. "Native American elders: Health care status." *Clin Geriatr Med* 1995; 11(1): 83-95). Since funeral directors and physicians unfamiliar with the decedent's life often fill out death certificates and since there is no formal quality assurance for Maine's vital records, it is very possible that Native American heritage is inaccurately reported in Maine's death certificates, as well as in other health data.

One Mainer's Perspective as a Native American Health Director

Patricia Knox-Nicola, Health Director, Penobscot Nation, Old Town

"During the past 20 years since the Indian Health Centers in Maine were established, we have been playing 'catch up' with health care."

"The current system for tracking ethnicity is not collected accurately or consistently. State agencies must train those who fill out forms how to accurately fill them out. Once accurate data are available, the Native American population and other minority groups will be better able to compete for funding, and ultimately the success rate of programs should increase."

One Mainer's Perspective as a French American

Judy Ayotte Paradis, Frenchville, Maine, former State Senator and Chair of Health and Human Services Committee of the Maine Legislature

Two Major Maine Franco-American Populations:

Acadians – French-speaking people living in the Maritimes, many of whom were forced by the British to flee New Brunswick and Nova Scotia during the 1750s and 1760s. While a number settled in faraway places such as Louisiana, Maryland, and even France, some settled in the St. John Valley in northern Maine.

Quebeçois: – French Canadians from Quebec, many of whom immigrated to Maine and other New England states in 1850–1900 and settled mostly in mill towns such as Lewiston, Waterville, Biddeford, and Augusta.

"Our French-American cultures – both Acadian and Quebeçois – teach us to be optimistic, and we have a tradition of strong spiritual faith. I think this optimism and strong faith in God contributes greatly to our good health. French-American families take care of each other – our extended families are very important. Also, we have a long tradition of working hard, particularly physical labor. I think smoking cigarettes or abusing alcohol is relatively rare in our populations."

"We have traditionally relied on home remedies that have been passed on from generation to generation to maintain our health. Many of us also have Native American ancestry. This has often been hidden, but can be seen in some of our traditions such as home remedies."

"French Americans with Quebeçois or Acadian ancestry tend to try to please and give optimistic answers, in part not to be burdensome. So, for instance, when encountering questions from health care providers about how they are doing, they may say "fine," even when things are not. I think it is important that if health care providers believe this may be happening that they ask the family member accompanying the patient as to how the patient is doing. The family member is more likely to give a direct answer than the patient."

"An example of this desire to be pleasing and not burdensome is when my parents have been hospitalized, they never wanted to ring the bell requesting assistance. Since we knew that, we made sure someone in the family was always with them. Also, I think it would help if hospital or nursing home staff make sure they periodically ask those patients and their family members how they are doing, rather than wait for the bell to ring."

"Language barriers are often seen among older Maine people with French-American ancestry. Even though they sometimes converse okay in English, a health care provider is often not going to get as accurate an answer unless they ask for the answer in French."

"Quebeçois and Acadian cultures are generally matriarchal since fathers so often had to work long hours away from home, or even away from the town in the woods and the mills. The mothers, therefore, were home and ruling the home. However, fathers do traditionally have the last word on some issues."

"My father recently died after a short illness at age 89. He had been in excellent health and I think this was because of his French-American culture. Like many Mainers with French-American ancestry, our family has Quebeçois and Acadian ancestry that both contribute to our culture. My parents had ten children. We were raised with no alcohol and no smoking allowed at home. Because my father was away so much working in the mill, my mother was the strong parent. Our extended family was very involved in raising us. We also took care of extended family members when they were ill or elderly. We were raised with a strong faith in God. I often saw my father on his knees praying and we prayed together as a family. When my father was recently terminally ill, he did not indicate much pain or ask for things. I think he didn't want to bother anyone and wanted to put forth an optimistic front. My parents' cultural legacies of hard work, optimism, and strong faith are seen today in us and all of their grandchildren. I'm very proud of this heritage my parents and ancestors gave to us."

Cultural Competency

Cultural competency is a set of behaviors and attitudes that enable us to understand and work effectively in cross-cultural situations. The result of cultural competency is the establishment of positive helping relationships that effectively engage people, and the significant improvement of quality of services such as public health and health care. In order to achieve cultural competence, the following should be included:

- **Valuing diversity;**
- **Having the capacity for cultural self-assessment;**
- **Being conscious of the dynamics inherent when cultures interact;**
- **Having institutionalized cultural knowledge; and**
- **Adapting service delivery based on understanding of cultural diversity.**

(Source: Office of Minority Health, DHHS.)

One Mainer's Perspective as a Southeast Asian American

Pirun Sen, Member of Maine's Cambodian Community and Home School Social Worker at the Multilingual Center, Portland Public Schools

According to Pirun, people from Cambodia prefer to be referred to as Southeast Asian Americans, not just Asian Americans.

"There are roughly 2,500 Cambodian Americans living in Maine, with a majority living in Portland, Sanford, and the Berwicks, while others are scattered across the State. The Buddhist Temple in Portland is often felt to be the center of the Cambodian Community in Maine."

"People from rural Cambodia especially often do not recognize the need for a doctor. In Cambodia, you could buy medicines very easily from a pharmacy without seeing a doctor. When most Southeast Asians finally go to a doctor, they usually go because they want medicine. They often do not understand the reasons behind the physical exams and tests."

"Life expectancy is very low in Cambodia – about 45 years old. People are not used to worrying about smoking or nutrition because in Cambodia something else will kill you before you have to worry about chronic diseases."

"Obesity was never a problem for us in Cambodia. We had to walk everywhere and ate a healthy diet. Here in the US our children do not have to walk like we did. Cambodians do not understand the push for physical activity – we never had a lack of physical activity before."

"Medical professionals do not understand Southeast Asian response to pain. They think we have a high pain tolerance. This is a misunderstanding. The pain is usually there and it hurts, but the old Cambodian belief is not to complain and hold it in, even if it is terrible. Also, our Buddhist religion tells us that if we're in pain, we're alive and should be happy."

"In Cambodian culture, our young children are mostly cared for by their grandparents and extended family. Adolescence is the time when parents become very involved with their children, in order to prepare them for adulthood. It is very difficult for Cambodian parents in this country when extended family is not present and when adolescents want to spend most of their time away from them."

Refugees

Of new immigrants, refugees especially experience many losses. They often:

- **Are severely traumatized by their past experiences;**
- **Worry about families and friends left behind;**
- **Lose much of their prior identity – such as leaving behind a profession and taking an entry-level job in the US; and**
- **Lose the cultural and physical environment that is familiar to them.**

(Source: Office of Minority Health, DHHS.)

One Mainer's Perspective as an African American

Anthony (Chan) Spotten, Executive Director and Founder of Health 2000, an organization working to raise awareness of AIDS among all Maine people of African descent. Chan was born in Maine and grew up in Old Town. His racial background is African American and Native American. He also is living with AIDS.

"Health issues for African Americans should not be separated from the history of being black in this country and the legacy of slavery. Life expectancy is the lowest among black men, HIV infection is in epidemic proportions among blacks, a significant proportion of the US prison and death row populations are black, and drug arrests are much higher among blacks. It is no surprise blacks sometimes may not take care of themselves better, considering they don't expect to live long anyway. Also, I think African Americans often feel that going to a doctor for preventive care would be considered unnecessarily taking up the doctor's time."

"I believe Maine needs an Office of Minority Health. There is insufficient health data and resulting efforts on minority health status in Maine, and this Office would assure the black community some inclusion and representation in Maine's health efforts. It would also train Maine's public health professionals on minority health and related data needs."

One Mainer's Perspective as an African American

Carl M. Toney, P.A. Assistant Professor and Project Director, Center for Transcultural Health, University of New England

"For African Americans, as well as for virtually all ethnic and cultural populations, the problem comes down to access to culturally appropriate care. Patients often lack confidence that their health care providers understand the health and social beliefs that are inherent in their cultures. This can become a barrier to individuals seeking care or feeling satisfied with a provider's response."

"African Americans are historically at risk for problems associated with cardiovascular disease and diabetes. When you combine these health factors with the issue of finding culturally sensitive care, it becomes a double-edged sword."

"The challenge is for health providers to establish a dialogue and a level of trust with patients of all ethnic populations. To successfully serve Maine as a whole, all parts must be accounted for and understood."

Two Mainers' Perspectives on Maine's Emerging Somali Population

Phil Nadeau, Assistant City Manager, Lewiston
Azeb Hassan, a Somali Community Interpreter and Advocate in Lewiston

Phil: *"I believe there are approximately 5,000 Somalis living in Maine, with about 3,500–4,000 living in Portland, and most of the remainder living here in Lewiston."*

Azeb: *"Tension is growing in many traditional Somali families around male and female roles within the family and community. It is customary for Somali women to remain in the home and care for children. Usually she does not leave home without her husband or his permission. It is also culturally acceptable to hit or beat your wife or for parents to discipline their children this way. Many Somali women are beginning to realize that they do not have to live this way anymore – being treated unfairly. Living in the US has showed them they can have jobs, interact freely with the external community, and have many options. However, these cultural differences are causing increased divorces and tensions."*

Azeb: *"Somalis living in Maine are mostly Muslim with strong religious and family values."*

Phil: *"Many of the Somali population suffered or witnessed torture of family members before coming to the US. We have been focusing on meeting basic housing and food needs, but it is clear we need to also connect people to appropriate mental health services."*

Azeb: *"We feel free here in Lewiston. We feel safe. We can go outside and not see anyone we're afraid of. My children are happy."*

Azeb: *"The Somali people want to work. We want to have jobs and own businesses. We want to contribute to the Lewiston community."*

Phil: *"I think the influx of Somali refugees in Lewiston will help turn around Lewiston's economy and will revive this city. We have been losing population for a long time now. The City of Lewiston has a wonderful history of immigration and it was the contribution of immigrants in the past that built this city. I believe the Somali people will also be an asset to Lewiston."*

AGE

NATIONALLY, WE KNOW:

- Our most vulnerable populations from a health standpoint tend to be the elderly and the young. Since other age groups are covered to some degree in *Healthy Maine 2010: Longer and Healthier Lives*, we have chosen to concentrate here on adolescents and young adults, defined as ages 10–24 years, and on elders, defined as individuals over age 64 years.
- Many health data systems obtain age of patients or respondents. What is presented here are just a few highlights describing some health challenges these two populations may face disparately.

Three Leading Causes Of Death In Each Age Group For A Sample Year US And Maine, Numbers Of Deaths

US 1997	MAINE 1998
Under 1 Year	
Birth defects 6,178	Disorders related to premature birth 34
Disorders related to premature birth 3,925	Birth defects 20
Sudden infant death syndrome (SIDS) 2,991	Probable SIDS or other ill-defined 12
1–4 Years	
Unintentional injuries 2,005	Unintentional injuries 4
Birth defects 589	Homicide 4
Cancer 438	Birth Defects 3
5–14 Years	
Unintentional injuries 3,371	Unintentional injuries 10
Cancer 1,030	Cancer 6
Homicide 457	Suicide 4
15–24 Years	
Unintentional injuries 13,367	Unintentional injuries 66
Homicide 6,146	Suicide 22
Suicide 4,186	Cancer 8
25–44 Years	
Unintentional injuries 27,129	Unintentional injuries 90
Cancer 21,706	Suicide 90
Heart disease 16,513	Cancer 86
45–64 Years	
Cancer 131,743	Cancer 674
Heart disease 101,235	Heart disease 405
Unintentional injuries 17,521	Unintentional injuries 69
65 Years and Older	
Heart disease 606,913	Heart disease 3,069
Cancer 382,913	Cancer 2,126
Stroke 140,366	Stroke 722

Source: Maine DHS, Bureau of Health, Vital Records; *Healthy People 2010*. Note: these numbers are only for a sample year and do not represent averages.

ADOLESCENTS AND YOUNG ADULTS

- The health of adolescents and young adults population is especially vulnerable for several major reasons, among them:
  - Rapid growth and development in adolescence leads to new needs; therefore adolescent health is intertwined with healthy development;
  - This is a period in which many lifelong patterns of behaviors are established;
  - Adolescent and young adult health provides the foundation for adult health status;
  - Societal messages to young people are often confusing and contradictory; making it difficult for young people to apply new skills and freedom around decision-making;
  - Adolescents under 18 make choices concerning their health, but are also still dependent on the adults in their lives for support and guidance, and do not have the same level of control over their environments as adults; and
  - "Problem-free is not fully prepared." (Karen Pittman)
- Adolescents and young adults (ages 10–24) comprise 21% of the US population, compared to 19.7% in Maine.

Penthea Burns, Maine Youth Leadership Advisory Team Coordinator, Portland

"You think about a patient's bill of rights and wonder what are the distinctions for adolescents in terms of the right and the need for privacy for their own empowerment and self-protection."

Maine Population By Sex And Age					
	1990 Census Number	% Of Total	2000 Census Number	% Of Total	Change Since '90
Total population	1,227,928		1,274,923		3.83%
Male	597,850	48.70%	620,309	48.70%	3.76%
Female	630,078	51.30%	654,614	51.30%	3.89%
Median Age	**34**		**39**		
0–4 years	85,722	7.00%	70,726	5.50%	–17.49%
5–9 years	88,506	7.20%	83,022	6.50%	–6.20%
10–14 years	84,579	6.90%	92,252	7.20%	9.07%
15–19 years	87,927	7.20%	89,485	7.00%	1.77%
20–24 years	86,040	7.00%	69,656	5.50%	–19.04%
25–34 years	205,235	16.70%	157,617	12.40%	–23.20%
35–44 years	193,345	15.70%	212,980	16.70%	10.16%
45–54 years	124,751	10.20%	192,596	15.10%	54.38%
55–59 years	54,216	4.40%	68,490	5.40%	26.33%
60–64 years	54,234	4.40%	54,697	4.30%	0.85%
65–74 years	91,600	7.50%	96,196	7.50%	5.02%
75–84 years	53,547	4.40%	63,890	5.00%	19.32%
85 years and over	18,226	1.50%	23,316	1.80%	27.93%

Source: US Census Bureau. http://factfinder.census.gov

- Nationally, approximately two-thirds of the population age 10–19 years are non-Hispanic white, and one-third are of other racial and ethnic groups. By the year 2050, national projections are that over half (56%) of this population will be Hispanic, black, American Indian, or Asian.
- Nationally, adolescents and young adults experience high rates of uninsurance – about one in five of them lack health insurance. Even more appear to lack dental insurance. This group also under-utilizes the health care system; foregoing needed acute and preventive health care more than other age groups.
- The most common reason for people in the US ages 10–24 to visit the emergency department is for injuries – accounting for half of all adolescent (ages 10–19) visits. Over half of these visits are for being struck, falls, cuts, and motor vehicle crashes. Almost three-quarters of all adolescent deaths are from injuries; only one-quarter are from diseases. Motor vehicle crashes and firearm-related injuries account for three-quarters of deaths from injury among adolescents, and 55% of all adolescent deaths.
- Nationally, tobacco addiction, alcohol use, marijuana use, suicide, sexually transmitted diseases, and injuries are all found in relatively high rates among adolescents and young adults compared to most other age groups.

Ryan Franchetti, 17, Board Member, Healthy Community Coalition, Farmington

"I still see a lot of teens smoking and most have no interest in quitting. The health messages only seem to get through to kids involved in sports. Another problem is the shortage of mental health services. There aren't enough places teens can go to for counseling on various family problems. They don't have anyone to talk to but friends who might not offer the best advice."

"Youth are under-represented in the community. Maine makes a good effort to talk to groups of kids through various programs and conferences. But those groups don't fully represent teenagers of Maine and all the health issues they face. When I attend conferences, I see the same kind of kids – the ones who do well in school and excel in all aspects of their lives."

"The kids who need help aren't the type to step forward or go through a visioning process."

Alana, 19; member of Maine Youth Leadership Advisory Team and a student at USM

"There's no real middle ground. You can find a counselor to talk to for an hour once a week or you can be hospitalized. At no point can you get someone to help with medication and monitor you for a while. I finally got an appointment with a psychiatrist, but he couldn't fit me in for three months. So, my therapist has actually recommended that if I really feel I need medication, I should get myself admitted someplace."

- The percentage of overweight young people in the US has doubled (increased by 100%) since 1980 (National Center for Health Statistics, US, 2000, Table 69).

ELDERS

- Because there are so many health status issues elders face that are measured and that are covered in *Healthy Maine 2010: Longer and Healthier Lives*, this chapter is focused on characterizing some of the factors seniors face that influence their health but are not necessarily directly related to the biological aging process per se.
- The median age in the US is 35, which is up from 33 in 1990 and 28 in 1970.

Jean Dellert, American Association of Retired Persons, Maine Chapter

"Prescription drug prices that seniors have to pay is one of the biggest issues the elders face."

- The percent of the US population over the age of 64 has increased from 6.9% in 1940 to 11.3% in 1980 to 12.3% in 2000, and is expected to increase dramatically over the next 20 years as the "baby boomer" generation reaches this age group.
- Although the vast majority of people over the age of 64 have health insurance through Medicare, many of them are underinsured. For instance, Medicare does not reimburse for most outpatient prescription drugs, one of the most expensive health care items in our overall health care budgets. Neither does Medicare cover dental care.
- Twenty-seven percent (27%) of elders and disabled Medicare recipients have no insurance to cover outpatient prescription drugs. (1998 Medicare Current Beneficiary Survey.)
- In 1999, seniors age 65 and older spent an average of $706 out-of-pocket for pharmaceuticals, which was nearly double the $370 spent by all consumers and seven times that spent by those under age 25 ($97).
  (Bureau of Labor Statistics, Consumer Expenditure Surveys 1999.)
- Employer-sponsored health insurance plans are the single largest source of supplemental coverage for Medicare beneficiaries; more than one-third of seniors have such coverage. This coverage tends to be more comprehensive and affordable than private Medigap or Medicare + Choice plans. Many companies who offer such benefits are planning on dropping this coverage or requiring retirees to share more of the cost. Most who still offer this benefit are large companies who offer it to employees who have worked there many years – a trend that is declining as well.
  ("Erosion of Private Health Insurance Coverage for Retirees," Kaiser Family Foundation, April 2002.)

- Most of the major chronic disease incidence and death rates rise with age, the exception being asthma.
- Depression, Alzheimer's, other dementias, and suicide are highest among elders. Depression tends to be undiagnosed and untreated relative to other age populations. Alcohol abuse and sexually transmitted diseases also tend to be underdiagnosed and untreated in elders. The Surgeon General's Report on Mental Health in 1999 reports that the estimated incidence of mental illness among adults age 55 and over is about 20%, or one in five.
- Occupational injuries are high among elders.
- Influenza and pneumococcal pneumonia are infectious diseases with a greater impact among elders, yet vaccinations against these two diseases can prevent them.

David Hall, American Association of Retired Persons, Maine Chapter

"There is a serious shortage of home care and nursing home staff, which reduces the quality of care available to elders. We are also challenged with educating the public about all the alternatives for elder care. Most elders want to live at home as long as possible."

- Physical activity and nutritional status tend to be poor among elders, yet vast improvements in health status can be made with modest interventions.

IN MAINE, WE KNOW:

- The median age in Maine is 39, which is up from 34 in 1990.
- As with national data, almost all Maine health data sets ask age. Therefore, compared with other disparity factors, there are more data on the effects age has on health status.

Median Ages US And Maine

	US	Maine
1970	28	
1990	33	34
2000	35	39

Source: 2000 Census.

ADOLESCENTS and YOUNG ADULTS

- Young adults are less likely to have health insurance. Twenty-two percent (22%) of Maine young adults ages 18–24 are uninsured, compared with those who are 45–64 (13%) and over 64 years (2%).
- Maine young adults have the lowest rate (69%) of using a car safety belt, compared with 82% for those over the age of 64.
- Adolescents and young adults have much higher smoking rates than older adults – 25% for high school students, 35% for ages 18–24 years, compared with 7% for those over age 64 (BRFSS 2000 and YRBS 2001).
- Maine teens ages 15–19 have a higher death rate from injuries, homicides, and suicides than the national rate (62/100,000 teens versus 53/100,000, in 1999).

Maine And US People Over Age 64 As A Percent Of The Total Population

	Maine	US
1940	6.9%	6.9%
1980	11.5%	11.3%
1990	13.3%	
2000	14.4%	12.3%
2020	*19.3%	

Source: US Census Bureau. * = Projection

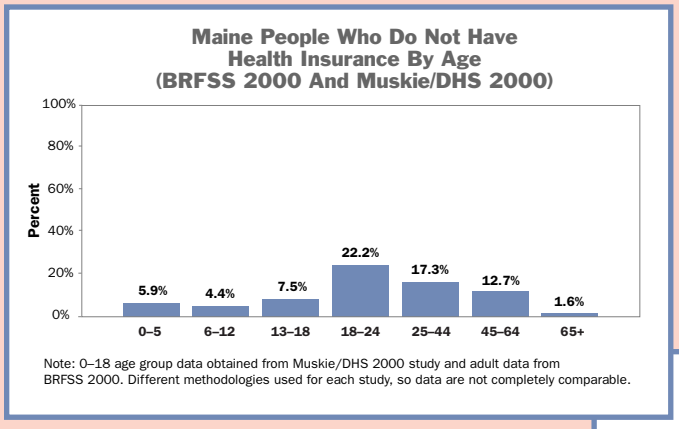
ELDERS

- Maine has one of the highest proportions of people over 64 years in the nation.
- Maine elders tend to live on fixed and lower incomes, and this limits their access to health care. Ten percent (10%) live below the Federal poverty level, which is $739 monthly income for a family of one.
- There are approximately 6,000 grandparents in Maine who are responsible for the care of their grandchildren. Sixty percent (60%) of these grandparents are women and 71% are in the labor force (2000 Census).
- Smoking rates among Maine's population over the age of 64 has shown a decline from 14% in 1993 to 6.8% in 2000.
- Mainers over 65 have the highest suicide rate of any group in the State, and suicide is the leading cause of injury death for Mainers age 65–74. Suicide rates among elders in Maine are about three times that for adolescents.

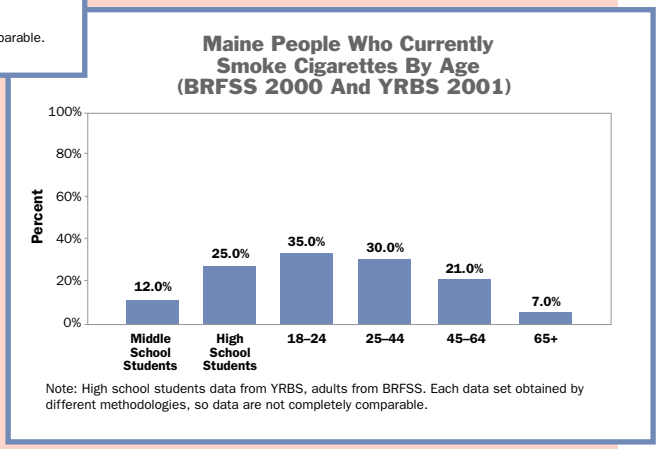
CHALLENGES

- Health data sets that rely on surveys of youth usually rely on those in regular public schools; missing some populations who may be at highest risk for health problems, such as those who dropped out of school or who are in correctional facilities. Also, most Maine health data on adolescents cannot be broken down by regions of the State.
- Overall, age is probably the factor with the least challenges in definition and measurement. Virtually all health data sets collect the respondent's or patient's age.
- We face challenges in moving from data gathering to data analysis to population-based interventions and then to evaluation.

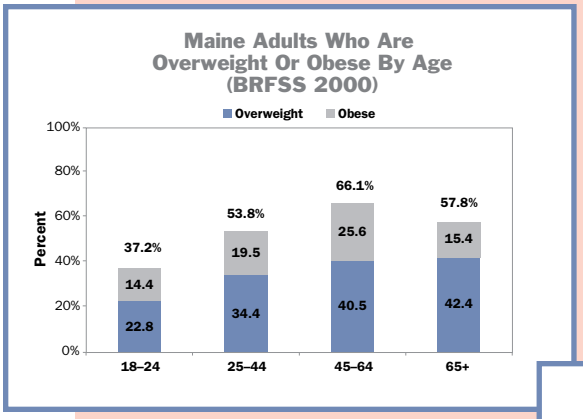
SOME SAMPLE BEHAVIORAL RISK FACTORS BY AGE IN MAINE:



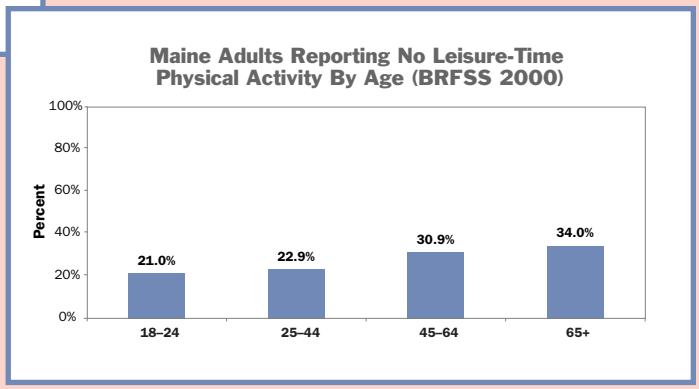
Younger adults are less likely to have health insurance than those age 45 and older.



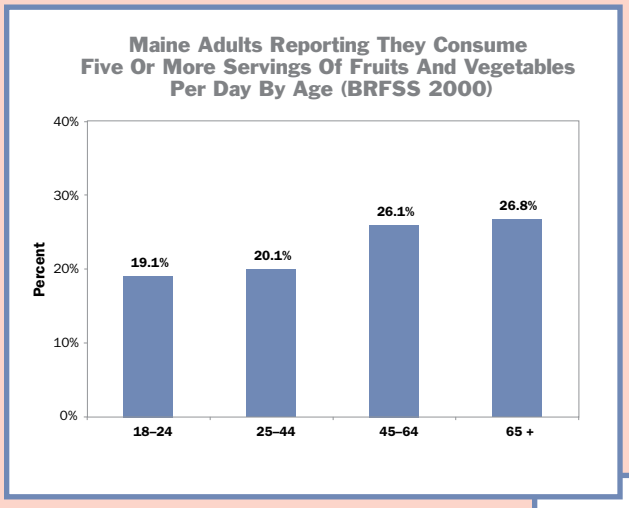
Younger adults are more likely to smoke than older adults.



Older adults are more likely to be overweight or obese than young adults.

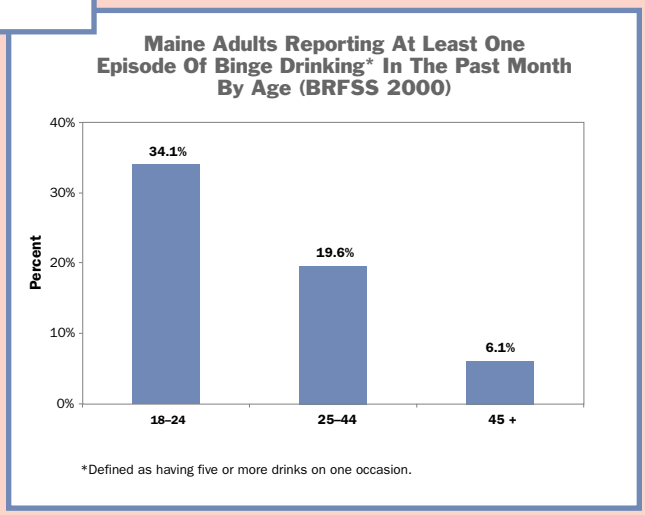


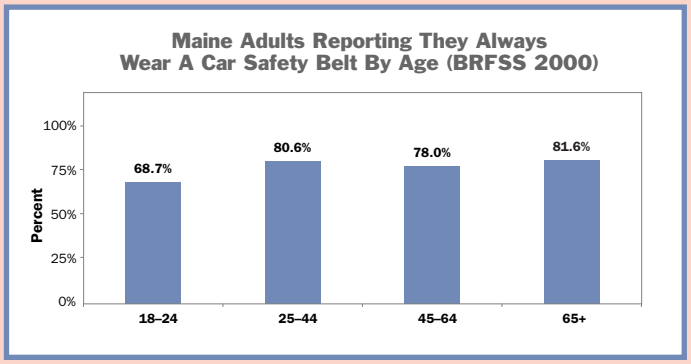
Older adults are less likely to engage in any leisure-time physical activity than younger adults.



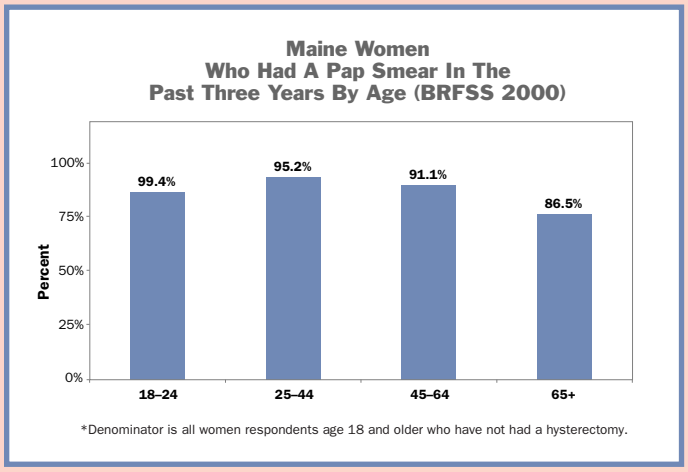
Younger adults are less likely to eat five or more servings of fruits and vegetables per day than older adults.

Younger adults are more likely to binge drink than older adults.

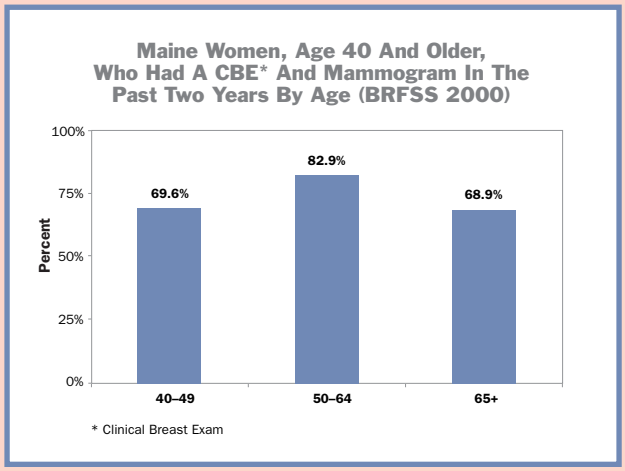




Younger adults are less likely to wear a car safety belt than older adults.

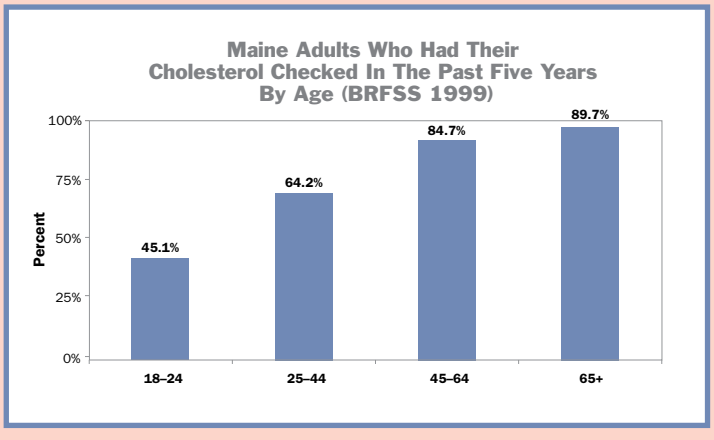


Older women are less likely to have had a Pap smear.



Women ages 40–50 or 65 and older are significantly less likely than women ages 50–64 to have had both a clinical breast exam and a mammogram in the past two years.

Younger adults are less likely to have had their cholesterol checked.



DISABILITY

NATIONALLY, WE KNOW:

- People with disabilities are generally identified as persons having an activity limitation, who use assistance, or who perceive themselves as having a disability. An estimated 21% of the population has some level of disability using this definition. The most common conditions or impairments that limit activity in descending order of frequency are: heart disease (13%), back problems (13%), arthritis, orthopedic conditions, asthma and diabetes, mental disorders, visual impairments, learning disabilities, and mental retardation. (National Health Interview Survey = DMMS, 2000.)

Dennis Fitzgibbons, Director of Operations, ALPHA ONE, South Portland, Maine

"Public policy leaders first need to get their hands around who the disabled community includes. It's not just people with physical disabilities, but those with brain injuries, mental health disabilities, and sensory impairment … there's quite a range."

"Most health professionals lack a basic understanding of the health issues people with disabilities face. Medical students across the country receive little education in what it means to have a disability. As a result, people with disabilities often have to educate their own physicians. There is a great opportunity for a person who is knowledgeable about his or her own disability to work with a provider who is willing to listen and learn. They could build a partnership that is much more effective in maintaining that patient's health."

- Defining disability is a challenge, especially for health data systems that measure the health impact of disabilities. Different data systems classify disabilities differently. Examples include:

  The Americans with Disabilities Act of 1990 (ADA) defines a disability as a "physical or mental impairment that substantially limits one or more major life activities."

  Social Security Administration, through which services such as Medicaid Health Insurance and financial resources are obtained, defines a disability as a physical or mental impairment that substantially impairs the person's ability to perform work (substantial gainful activity), and the condition must have existed or is expected to continue to exist for at least one year.

- Other challenges in defining disabilities include:

  Some disabilities, such as mental disorders, may be only temporary, yet others are lifelong.

  Often, people in the deaf culture who use American Sign Language do not consider themselves disabled, yet deafness is often included in measurement tools as a disability.

- Rates of disability for both sexes increase with age.

- Rates of disability are rising for people under 45 years.

- Disability and underlying conditions disproportionately affect women, partially due to a longer life expectancy.
- Having a disability is associated with higher rates of poverty, living alone, unemployment, low education, physical inactivity, obesity, pain, sleeplessness, depression, and anxiety, even when disability rates are adjusted for age.
- Many people with disabilities lack access to health services and medical care.

Meryl Troop, Office of Deaf and Multicultural Services, Maine Dept. of Behavioral and Developmental Services, and (in mirror) Romy Spitz, Ph.D., Technical Consultant on Deafness, Mobius Inc., and researcher at USM

"Communication with health care professionals is a special challenge for people who are deaf and hard of hearing. Very few providers in Maine use sign language and professional interpreters are rarely hired. There is also a shortage of assistive listening devices, TTY equipment, and training on relay services. Deaf people need to be better accommodated in visiting nurse programs, nursing homes, and all facets of health care."

IN MAINE, WE KNOW:

- There is no consistent statewide system for measuring how many Maine people have disabilities, and what the impact of their disabilities is on their health. Existing data systems are primarily those that serve different populations with disabilities such as MaineCare and Maine's Division of Vocational Rehabilitation.
- The Behavioral Risk Factor Surveillance System (BRFSS) has recently started asking disability-related questions, but there are not yet enough data to assess the impact these disabilities have on health:

  In 2000 and 2001, Maine BRFSS asked: "During the past 30 days, did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"
  None: 80%
  20% replied "yes," with a median of 5 days (both in 2000 and 2001) out of 30.

  In 2001, Maine BRFSS asked: "Are you limited in any way in any activities because of physical, mental, or emotional problems?"
  Preliminary results show: 19% Yes

  In 2001, Maine BRFSS asked "Do you now have any health problems that require you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?"
  Preliminary results show: 5.7% Yes
- MaineCare insures about 35,000 disabled low income people. (See Access Chapter *Healthy Maine 2010: Living Longer and Healthier Lives* for additional information.)

- The Division of Vocational Rehabilitation served 5,379 people in 2000, one-third (1,790) of whom were clients with a mental illness, one-quarter of whom were diagnosed with an orthopedic condition, and nearly one quarter of whom were diagnosed with other physical disabilities.
- The US Census defines a person as having a disability when he or she is identified as having blindness, deafness, severe vision or hearing impairment; or a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying. According to the 2000 Census, an estimated 141,000 Maine people age 21–64, or approximately 19% of that population, are disabled. This is the same as the national rate for this age group.

  In Maine, 42% of non-institutionalized people with disabilities are employed, compared with 33% nationally.
  (US Census Bureau and Maine Economic Growth Council, 2002 Measures of Growth report. Summary and analysis done by the Maine Development Foundation.)

  According to the 2000 Census, an estimated 25,000 Maine children ages 5–20 years are disabled, approximately 9% of that population. By comparison, 8% of the US population ages 5–20 are disabled.

  According to the 2000 Census, an estimated 72,000 Maine people over the age of 64 are disabled, which is approximately 41% of this population.

  The total population in Maine with a disability is estimated to be 325,500 by the 2000 Census, which is approximately 26%, or one in four, of the population.
- Eight and a half percent (8.5%) of Maine's population (just over 100,000 people) are deaf or hard of hearing. Of this number, 10% (about 10,200 people) are profoundly deaf.
  (Source: Maine Department of Behavioral and Developmental Services.)
- Hearing aids are not covered by MaineCare or by most insurers.
- Only about 35% of English is visible through lip reading; therefore, it is difficult if not impossible for the deaf to communicate with health care providers without an interpreter. However, the hourly rate for a sign language interpreter in Maine is $50, including travel time. Four Maine counties have no interpreter at all. Partial payment for interpreting services is reimbursed through MaineCare, and Maine is only one of three states that have any reimbursement. University of Southern Maine is graduating its first class in sign language interpretation in 2003.

CHALLENGES

- There is a need to develop consistent and concise ways to determine and define disability status so that it can be measured by more health data systems in Maine; yet also be comparable, as much as possible, with national health data systems.
- The Bureau of Health is expanding its questions on disability status through BRFSS. This will eventually provide some statewide estimates that can give some additional characterizations such as age, gender, and geographical distributions of people living with disabilities in Maine. This will also be comparable with national BRFSS data.
- The Bureau of Health lost ground in addressing some of these challenges when its Disability Program was de-funded in the 1990's. However, the Bureau hopes to move forward in improving health measurements regarding disability status.

GENDER

NATIONALLY, WE KNOW:

- Although some differences in health experienced by men and women are the result of biological differences, others appear more complicated and are perhaps the result of social and environmental differences.
- Men have a life expectancy that is six years less than that for women, and have higher death rates for each of the ten leading causes of death. Although *rates* of death for some common diseases are higher among men, the *numbers* of deaths are sometimes higher among women because women live longer and, therefore, the population of older women is much higher.
- Men are two times more likely than women to die from unintentional injuries and five times more likely than women to die from firearm-related injuries.
- Motor vehicle deaths among males are twice the rate among females; homicide deaths among males are three times the rate among females.
- Heart disease death rates continue to decline for the whole population, but the decline is not as great for women as it is for men.
- Death rates for women are rising for some major diseases such as lung cancer, while men's death rates have slowed.
- Women are more likely to be disabled.
- Women are more likely to be diagnosed with a chronic condition such as Alzheimer's disease, arthritis, and osteoporosis, autoimmune disorders such as lupus and multiple sclerosis, and mental illnesses such as major depression (twice as likely) and anxiety disorders.
- Women are more likely to be the victims of domestic violence.
- Men are less likely than women to seek routine medical care, and they are also less likely to engage in preventive health care and activities. Only 82% of men report an ongoing source of primary care, compared to 90% of women. Men are also more likely to lack health insurance (17% of adult men under age 65, compared to 15% women under age 65). They are more likely to delay obtaining medical care when they have symptoms. All these factors may contribute to men's increased death rates from preventable diseases.
  (Sources: BRFSS, 2000 and 1999.)
- Men are three times more likely to binge drink than women.
- Smoking prevalence among men is 25%, compared to 22% among women.
- Women are more likely to eat the recommended number of fruits and vegetables.

Gender-Based Analysis

"Gender-based analysis challenges the assumption that everyone is affected by policies, programs, and legislation in the same way regardless of gender, a notion often referred to as 'gender-neutral policy.' ... Originally it was believed that equality could be achieved by giving women and men the same opportunities, on the assumption that this would bring sameness of results. However, same treatment was found not necessarily to yield equal results. Today, the concept of equality acknowledges that different treatment of women and men may sometimes be required to achieve sameness of results, because of different life conditions."

Excerpted from *Gender-Based Analysis: A Guide for Policy-Making*, Status of Women Canada.

- Women in the US earned only 73 cents for every dollar men were paid in 1999, according to Census figures.
- The proportion of women living in poverty has historically been greater than that for men. Older women especially are more likely to live in poverty and live alone. Women account for most nursing home patients.
- Women are more likely to be caregivers and make the majority of health care decisions within families.
- Historically, women's health has focused largely on reproductive and childbirth issues. However, for years, women of childbearing age were excluded from medical research trials; resulting in medical research and practice being largely based in a male-centric, scientific view of biology and human nature.

Median Age By Gender, 1999

	Maine	US
Females	38.6	36.6
Males	36.9	34.3

Source: Census.

- Very little information exists on health disparities experienced by transgender populations, in large part because data systems generally do not ask transgender status. (See Sexual Orientation chapter for more information, since this chapter also covers sexual minorities in general.)

IN MAINE WE KNOW:

- The average age of women is higher than men since women's life expectancy is longer. Because of Maine's higher proportion of older people, the average age of Maine women and men is older than the US average.
- Maine women are more likely to live in poverty than their male counterparts. Approximately one in six women in Maine live in poverty. About half of Maine women with incomes less than $16,000 have no health insurance.

Maine Women's Health Campaign

In 1996, The Maine Women's Health Campaign (MWHC) was established by the Department of Human Services' Bureau of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services (now the Department of Behavioral and Developmental Services), the American Cancer Society, Medical Care Development, and other private women's health and advocacy organizations to provide a structure for working together to better address women's health issues. Since that time, *Women's Health: A Maine Profile* has been published in 1998 and 2002; *Girls' Health: A Maine Profile*, was published in 2001; action plans for women's health and girls' health were published in 1999 and 2001, respectively; and women's health and girls' health summits were held in 1998 and 2001, respectively.

To obtain copies of the above publications or other information on the Maine Women's Health Campaign, contact Medical Care Development at (207) 622-7566, ext. 256. The coordinator for Women's Health in State Government is Sharon Leahy-Lind at (207) 287-4577.

- Maine women earn 75 cents for every dollar earned by their male counterparts, but women ages 15–44 have out-of-pocket expenses for health care services that are 68% higher than those of men the same age.
- Sixty-one (61%) of Maine females 16 years and older are in the labor force.
- About three out of four nursing home residents in Maine are women.
- Maine data also indicate higher rates of preventive care and activities and health insurance, as well as lower death rates from preventable diseases among women compared to their male counterparts.
- The estimated prevalence of smoking among Maine men is slightly higher than among Maine women – 25% of men and 23% of women in Maine report current cigarette smoking. (See the Substance Abuse chapter of *Healthy Maine 2010: Longer and Healthier Lives*.)
- However, there are two disturbing trends seen among Maine women and smoking. These trends point out the importance of gender analysis of health data. First, over the past 10 years smoking rates among Maine men have declined from 31% in 1990 to 25% in 2000, while smoking rates among Maine women have not changed (23% in 1990, 23% in 2001).

Erik Steele, D.O. Family Physician and Vice President of Patient Care Services, Eastern Maine Medical Center

"With men dying at younger ages than women and with studies showing they are less likely to get medical care and carry out preventive health activities, it is important that we figure out ways to get men to take better care of themselves. This isn't just a men's health issue but a family issue."

"With such low rates of preventive care such as screening tests, we really don't even know the true rate of some diseases in men."

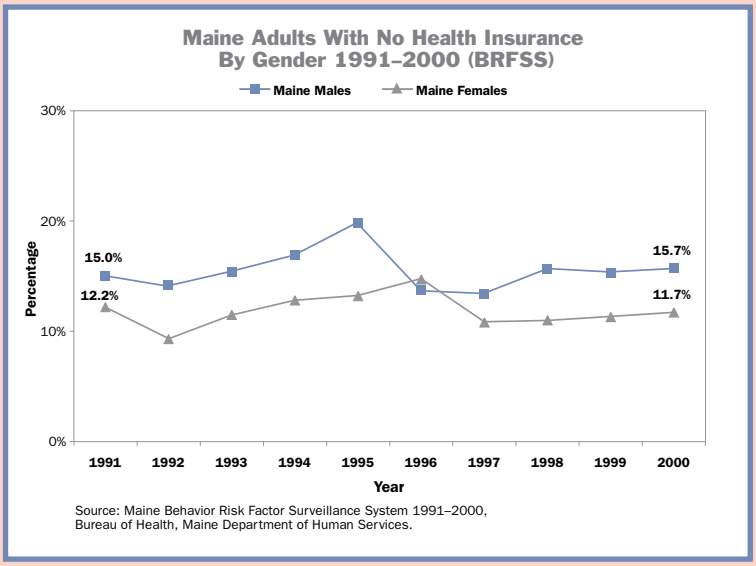
- Secondly, disturbing trends exist among Maine girls regarding smoking. Among Maine middle school students, it appears that girls are slightly more likely to be current smokers (12%) compared to their boy counterparts (7.7%) (YRBS 2001). Likewise, among Maine high school students, it appears that girls are slightly more likely to be current smokers (27%) than their boy counterparts (23%) (YRBS 2001). Unlike their adult counterparts, it appears that Maine middle and high school girls smoke at higher rates than boys. Again, this closer look at smoking rates shows the importance of gender analysis of health data.
- Rates of death among Maine men from:
  - heart disease are 49% higher than among Maine women;
  - stroke are 9% higher than among Maine women;
  - lung cancer are 71% higher than among Maine women;
  - diabetes are 16% higher than among Maine women;
  - suicide are almost four times higher than among Maine women;
  - motor vehicle crashes are about twice as high than among Maine women; and
  - firearm-related injuries are about five times higher than among Maine women.

- Although heart disease death rates continue to decline for the whole population, in Maine the decline for women is not as great as it is for men.
- Lung cancer death rates have declined for Maine men in recent years, while they have risen for Maine women.
- Although rates of death for some common diseases are higher among men, the numbers of deaths are sometimes higher among women because women live longer and, therefore, the population of older women is much higher:
  - More Maine women die from heart disease than men (about 1,800 per year versus 1,700).
  - More Maine women die from stroke than men (about 470 per year versus 300).
  - Maine women are more likely to be a victim of reported domestic assault with resulting physical injuries.
- While overall crime in Maine is declining, violent crime, rape, and domestic violence all increased in 2000.
  - Rapes increased by 19.2% from 1998 to 1999 and by 16.5% from 1999 to 2000.
  - There were 4,468 domestic assaults in 2000, an increase of 12.5% following two years of decline. Male assaults on females are approximately five times more frequent than female assaults on males. (See the Injury chapter of *Healthy Maine 2010: Longer and Healthier Lives* for more information.)

Connie Adler, M.D., Family Physician, Pine Tree Women's Care in Farmington, former Medical Director of Maine's Breast and Cervical Health Program

"Violence against women is one of the huge public health issues that needs to be addressed in Maine. Access to care in rural areas is clearly another big issue. There is a shortage of health care providers who are experienced in women's health issues, including menopause. The lack of mental health facilities and access to counseling is also of concern."

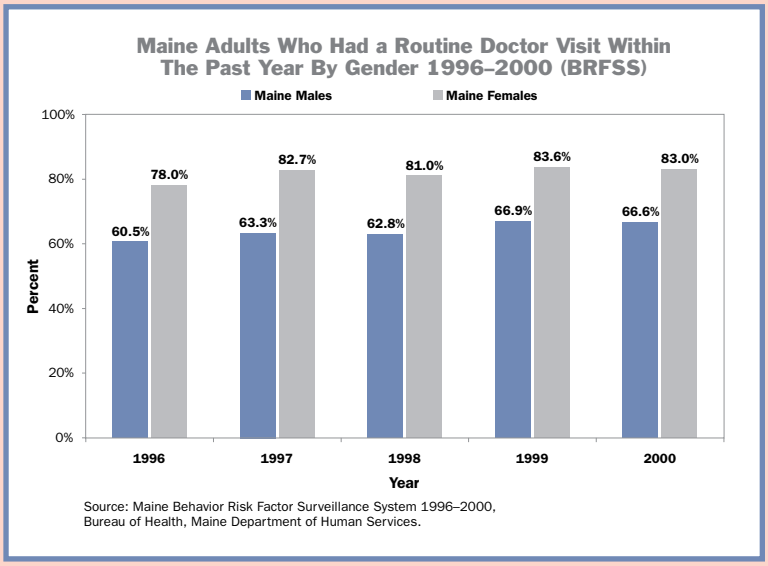
"Smoking is a huge problem among women in Maine. As a health care provider, I need more reporting of gender-specific results from studies of smoking prevention and cessation interventions and the health effects of tobacco products. This will help me to tailor my work to best address the needs of women in my practice."



Source: Maine Behavior Risk Factor Surveillance System 1991–2000, Bureau of Health, Maine Department of Human Services.

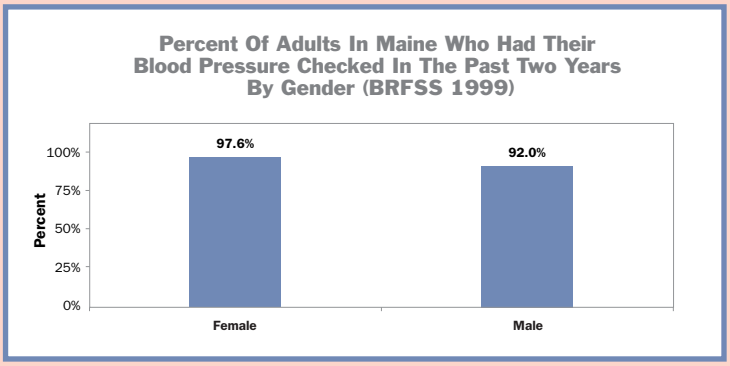
Maine women usually have higher rates of having health insurance than men. This is, at least in part, due to MaineCare's coverage of women during pregnancy – up to 200% of Federal poverty level.

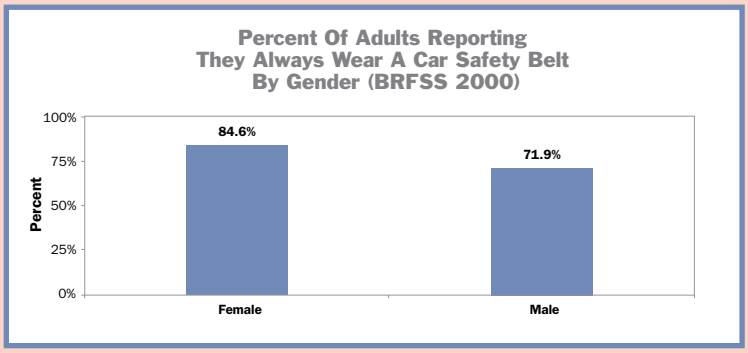
Maine women are more likely to have made a routine doctor visit within the past year than Maine men.



Source: Maine Behavior Risk Factor Surveillance System 1996–2000, Bureau of Health, Maine Department of Human Services.

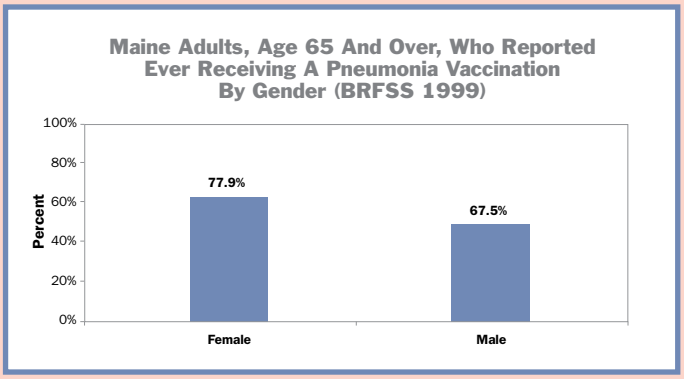
Maine women are more likely to have had their blood pressure checked in the past two years than Maine men.



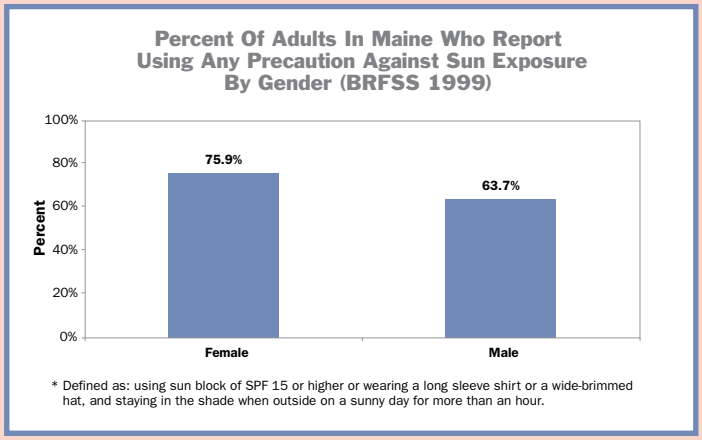


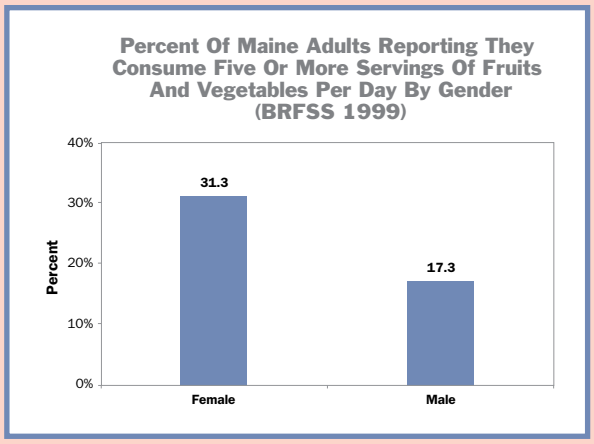
Maine women are more likely to report always wearing a car safety belt than Maine men.

Maine women aged 65 and over are more likely to receive a pneumonia vaccination than their male counterparts.

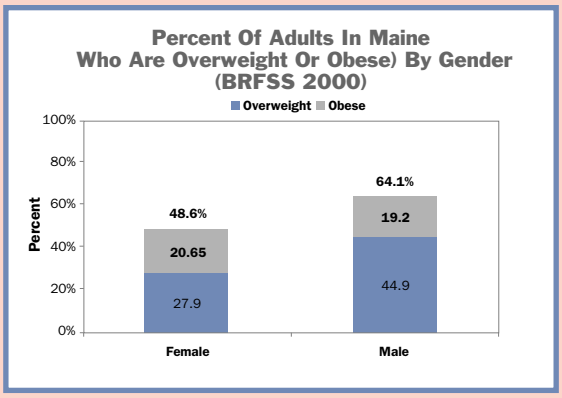


Maine women are more likely to use some type of sun protection (sun block or protective clothing) against the sun than their male counterparts.

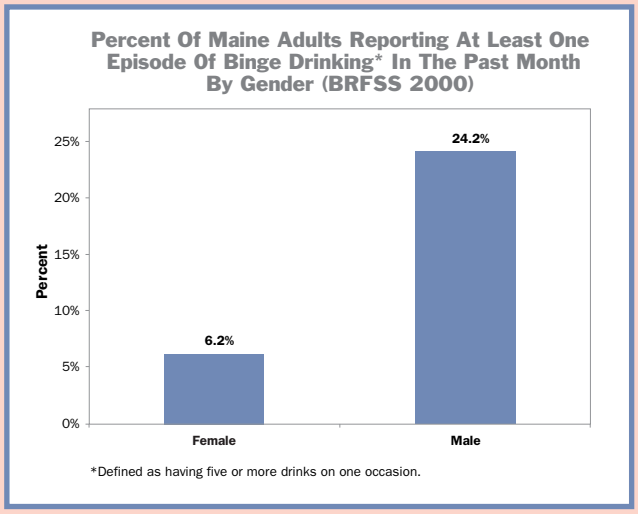




Maine women are more likely to eat five or more servings of fruits and vegetables per day than Maine men.



Maine men are more likely to be overweight and about equally likely to be obese compared to Maine women.

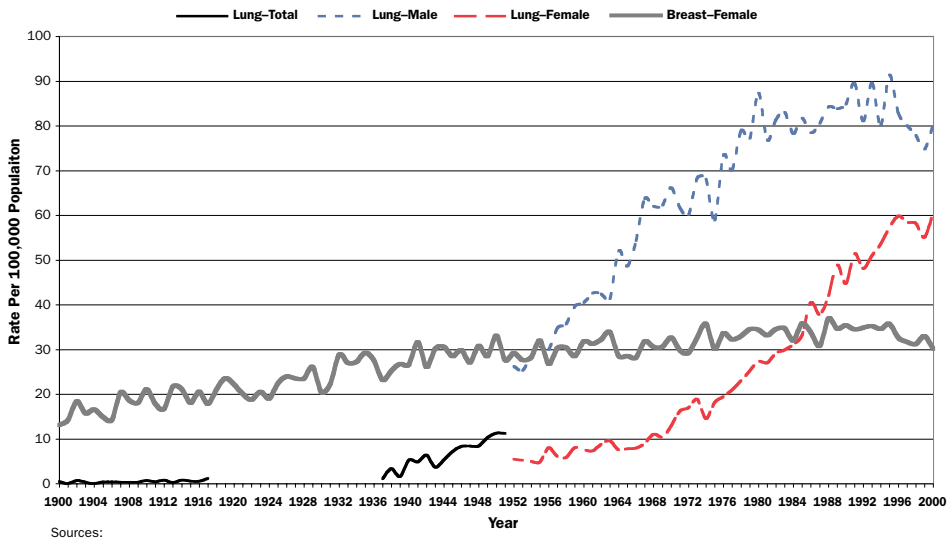


Maine men are more likely than Maine women to binge drink.

CHALLENGES:

- Research is making it increasingly clear that gender-specific and gender-appropriate strategies to address health issues are often needed. Differences between genders must be acknowledged in the following ways to assure this is achieved:
  - Gender-based analysis of all health data; and
  - Gender-specific interventions when appropriate.
- Because male and female gender are included in most major health data systems, it should be possible to identify, focus, and evaluate existing efforts to address health needs experienced by male and females.
- A major challenge Maine faces is building the capacity to collect, analyze, and appropriately disseminate health data by gender to assure its effective use, as well as increasing the ability of program planners and policymakers to appropriately consider and address gender in interventions. In addition, public health interventions must be increasingly targeted to reach men and women in gender appropriate ways. The new (2002) Coordinator of Women's Health should help start building these capacities.
- What about men's health? Currently, there is a focus on women's health because health research has traditionally focused on men and, therefore, many current interventions are implemented on entire populations with a male-orientation and without knowledge of gender differences. Additionally, because women are most often the primary health caregiver of a family and because they consult a doctor 150% more frequently than men, it is important women understand health issues of all their family members. However, particularly because men use preventive health services less frequently and because their death rates are higher, it is important to focus on specific men's health strategies as more resources become available.
- The differences between girls and boys are equally important as those between women and men, yet few health data systems are focused on youth.
- Almost no health data address transgender status. (See the Sexual Orientation Section beginning on page 61.)

Maine Lung And Breast Cancer Deaths Per 100,000 Population, 1900–2000



Sources:
Mortality Data: Maine Vital Statistics annual reports, 1892–1998; electronic files, 1999–2000.
Total Population: Maine Vital Statistics annual reports, 1892–1900; revised estimates, 1991–1999; US Census, 2000.
Gender Population: US Census Bureau, 1880–1960, 1980, 1990; CDC Wonder, 1970–1979;
ORDRVS intercensal estimates, 1981–1989, 1991–1999 (revised estimates).

NOTE: Number of breast cancer deaths for 1900–1909, 1920–1934 and 1946–1951 are for all persons, not just females.
Lung cancer data are not available from 1918–1936.

NOTE: Data are not age-adjusted.

Women's rates of death from lung cancer have corresponded with their smoking, with approximately a 20-year lag from significant changes in smoking rates. In the 1980s, women's rates of death from lung cancer surpassed death rates from breast cancer, and their rates of death from lung cancer continue to rise. Among men, lung cancer death rates began to decline in the early 1990s.

SIGNIFICANT LIFE EVENT: VETERAN STATUS

Sometimes significant life events or situations influence our health status. Examples include being married, divorced, or single; experiencing the death of a loved one; working in an occupation associated with some health issues; being homeless; being imprisoned; immigrating to a new country; being an abused or neglected child; or being the victim of violence. Since there are so many life situations that could be examined to discern their impact on health, and since some are covered to an extent in other chapters (victim violence in the Injury chapter of *Healthy Maine 2010: Longer and Healthier Lives*), limited resources make it necessary to focus on only one life situation as an example.

Veteran status is chosen as the focus for this chapter. Since September 11 2001, we are more aware of the sacrifice military men and women have played in defending the freedom we enjoy. With increasing numbers of our armed services working in war-torn areas of the world and expected to return someday to our communities, it appears timely to look at the health issues they may face. Especially since they may be witnessing tremendous violence, being under attack themselves, and possibly being exposed to biological or chemical weapons with long-term effects, assuring their overall health status is addressed when they return is important. Additionally, with veterans from World War II, Korea, and Vietnam becoming older, the overall health status of veterans living among us appears to be a growing issue.

Larry Dearborn, Past State Commander of the American Legion and State Director of the Uniformed Services Disabled Retirees, and Member and a Past Post Director of Post 9 of the Veterans of Foreign Wars, and Vietnam Veteran

"Getting to see a doctor is one of the biggest health challenges for veterans in Maine. I have a 100% disability due to my military service, so I have a priority in the VA Health System. I'm also hard of hearing, yet it still takes me 8–12 months to get my hearing re-checked for a new hearing aid. And, the appointment is for a place one and one-half hours from where I live. The people who work in the VA System, such as at Togus, are wonderful people, but they are woefully underfunded."

"Transportation is a big barrier, especially among the elder veterans. Services, especially specialty services, are only available in certain areas of the State or in Boston. Although there are some limited transportation services available, you can't ask an elderly veteran to hop from their home to the town's bus stop to their appointment and back again."

"I would recommend that if community-based public health organizations want to become involved in working with veterans, that they contact their local American Legion or VFW post. I think they will find a very willing group of hardworking people."

NATIONALLY WE KNOW:

Jerry O'Neill, Commander of Deering Memorial Post No. 6859, Portland Maine

- There are about 25 million veterans.
- Two-thirds of the male population over age 65 are veterans.
- The veteran population is aging, with an expected increase in their median age from 57 years in 1995 to 63 years in 2010.
- The median age of women veterans is younger, 45 years versus 58 years for men. While the total numbers of veterans are declining, the numbers of women veterans are increasing.
- Nearly 25% of homeless people are veterans and many veterans who live in poverty are at risk of becoming homeless.
- Smoking rates appear to be higher, about 30% compared to about 25% in the overall population nationally (http://www.va.gov).
- The US Department of Veterans Affairs (VA) administers the VA Health Administration throughout the US that provides some health services to those who served in the military and left with an honorable discharge. However, benefits are limited and co-payments can be considerable, depending on a veteran's income, disability status, and place of residence.
- A recent interim report by the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans sets a course of collaboration between two parallel but related health care systems – health care systems run separately by the Department of Veteran's Affairs (VA) and the Department of Defense (DOD).
  (Interim Report, July 31, 2002, available at www.presidentshealthcare.org)
- For example, despite known occupational hazards our military personnel face such as chemical exposures and psychological trauma, this report states: "Occupational health information is not collected in a formal or structured way across the Services; the DOD does not currently view collection of this information as a defined requirement."

IN MAINE WE KNOW:

- According to the 2000 Census, there are approximately 154,000 civilian veterans in Maine, which is an estimated 16% or one in six of the adult civilian population.
- Maine has the highest concentration of veterans in the United States. Other states with high percentages of veterans in its adult civilian populations include Nevada, Florida, Montana, and Oklahoma.
  (Bureau of Veterans' Services.)
- Of Maine's 154,000 veterans, approximately 5.8% of them are women, but this percentage is increasing as the total numbers of women veterans increases in Maine.
- As of 2000, there are an estimated 2,300 residents in Maine serving currently in the armed forces.

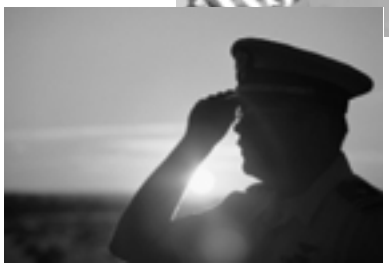
COUNTY	Numbers Of Veterans	VA Enrollees	% Of Veterans Enrolled
Androscoggin	13,168	3,330	25%
Aroostook	9,960	3,331	33%
Cumberland	29,929	5,057	17%
Franklin	3,482	1,018	29%
Hancock	6,203	1,219	20%
Kennebec	14,390	4,736	33%
Knox	4,880	1,126	23%
Lincoln	3,960	1,152	29%
Oxford	6,800	2,149	32%
Penobscot	18,009	3,989	22%
Piscataquis	2,365	786	33%
Sagadahoc	4,609	1,063	23%
Somerset	6,244	1,914	31%
Waldo	4,137	1,063	26%
Washington	4,721	1,496	32%
York	21,154	4,267	20%
Maine Total	**154,013**	**37,696**	**24%**

VA Enrollees are those enrolled in the VA Health System. Source: Department of Veterans' Affairs.

Robert Owen, Department Service Officer of the American Legion of Maine, Member of the Veterans of Foreign Wars and Korean War Veteran

"Lack of funding for health care for vets is the biggest health issue veterans face. Congress has continued to not fund the VA at the level needed and, meanwhile, the population the VA serves has grown. As a result, in Maine it takes about one year for a newly eligible veteran to even see a primary care physician. Just because there is a veterans' health care system and just because a veteran may be a member of it, doesn't mean they are served by it."

- Approximately 24% of Maine's veterans are enrolled in the US Department of Veterans' Affairs (VA) health care services in Maine (see the county enrollment table).
- The VA operates a medical center in Togus, near Augusta. Established by President Lincoln in 1865 and opened in 1866, Togus was the *first* national home for disabled volunteer soldiers. At one time it housed about 3,000 veterans, though the hospital part of it was much smaller. In 2001, inpatient admissions at Togus were 2,147, while outpatient visits reached over 222,000. Community-based outpatient clinics are operated in Caribou, Bangor, Calais, Machias, Rumford, and Saco.
- Veteran centers that provide counseling are located in Bangor, Caribou, Lewiston, Portland, and Springvale.
- Veterans' homes that operate as long-term care facilities are located in Augusta, Bangor, Caribou, Scarborough, and South Paris.
- Various estimates place the numbers of homeless veterans in Maine at 500–1,000 or even higher. Local veteran groups periodically hold "stand-downs" in urban area homeless shelters in Maine to provide assistance to homeless veterans. However, there are no facilities specially designated for homeless veterans.



- The Bureau of Veterans' Services in the Maine Department of Defense, Veterans, and Emergency Management provides informational services to veterans and their dependents across Maine regarding Federal, State, and local assistance.
- The American Legion was chartered by Congress in 1919 to serve members of the US armed forces who served during a time of national crisis, regardless of place of service. It is also a community service organization with auxiliary organizations. The American Legion in Maine has over 26,000 veteran members, 13,000 auxiliary members, and about 3,000 members of the Sons of the American Legion with a total approaching 50,000. One hundred sixty-six (166) posts are located throughout the State.
- The Veterans of Foreign Wars, or VFW, traces its roots to 1899 when veterans of the Spanish-American War and the Philippine Insurrection founded local organizations to address their needs. Membership includes veterans from four wars and active-duty service members who have earned an overseas campaign. The VFW is also a community service organization with auxiliary organizations. The VFW in Maine has about 82 posts with 16,000 members and 54 auxiliary units with 5,500 auxiliary members located throughout the State.

CHALLENGES

- Veteran status in Maine is collected by a few health data systems: the Census, BRFSS, death certificates, and the substance abuse Treatment Data System (see the appendix). The VA has information on the utilization of its health care system by its enrollees, but has a limited amount of population-based data that tracks overall health status. However, it appears that a more comprehensive analysis of Maine veterans' health as a population is possible, given the several data sets that collect information on veteran status. The Bureau of Health hopes to work with others to identify resources for such an analysis.
- There are many Statewide infrastructure components that can be used to reach out to veteran populations. Many communities have an American Legion or Veterans of Foreign Wars post, the Maine Bureau of Veterans' Services has some local offices, and the VA Health Administration has facilities in several towns. Therefore, it should be relatively easy for local public health initiatives to include veterans in their outreach.

RESIDENCE: RURAL *and* URBAN

NATIONALLY, WE KNOW:

- Twenty percent (20%) of Americans live in rural areas, defined as places with fewer than 2,500 residents.
- Although some health disparities between rural and urban residents may be a direct result of the inherent structural differences of a rural area, some are clearly the result of a complex interaction among structural, cultural, and economic differences.
- Poverty is higher in rural areas. Fourteen percent (14%) of rural Americans lived in poverty compared to 11% of urban Americans in 1999 (Census).
- Rural residents have fewer health care providers per capita and increased transportation barriers. For example, only 9% of the nation's physicians practice in rural areas, even though 20% of the population lives there. There especially appears to be a shortage of dentists in rural areas compared to urban areas.

David Hartley, PhD, MHA, Chair, Master's Program in Health Policy and Management, Edmund S. Muskie School of Public Service, University of Southern Maine

"One of the biggest challenges for improving health of rural Mainers is to begin to understand the underlying cultural issues that lead to unhealthy behaviors and develop culturally appropriate initiatives to change them. These will quite likely be different from one community to the next."

"A second challenge is to begin to effect a change in the medical community toward a population perspective that acknowledges these cultural factors and takes them on, helping every primary care practitioner to accept responsibility for population health."

"A third challenge, and perhaps the most difficult, is to distribute responsibility for population health across a broader spectrum of the leadership of rural communities by means of multi-sector partnerships. The business community, schools, municipal government, and the citizenry must recognize that economic health, social health, and physical health are intimately related, and that the future welfare of each rural community depends on an integrated, collaborative effort across all the factors that make for a healthy rural community."

"The health of rural Mainers is directly connected to the health of rural Maine communities."

Critical Access Hospital Program (Maine Rural Hospital Flexibility Program)

This Federally-funded program, administered by the Maine Department of Human Services' Bureaus of Health and Medical Services, allows rural hospitals to convert to cost-based reimbursements under Medicare and Medicaid (MaineCare). In exchange, the hospital agrees to continue 24-hour emergency services and provide appropriate staff, but to limit the number of inpatient acute care beds (15 acute care beds and 10 swing beds for a total of 25 licensed beds).

This program was created in 1997 by Congress to address the problem that many of our country's rural hospitals serve a higher proportion of elders and low income people and, therefore, are often more highly dependent on Medicare and Medicaid funds.

As of August 2002, seven Maine hospitals have converted to CAH license:

- **Blue Hill Hospital**
- **Calais Regional Hospital**
- **Penobscot Valley Hospital in Lincoln**
- **St. Andrews Hospital in Boothbay Harbor**
- **CA Dean Hospital in Greenville**
- **Mount Desert Island Hospital in Bar Harbor**
- **Rumford Hospital**

- Because there are fewer specialists in rural areas, primary care providers (such as family physicians, pediatricians, internists, nurse practitioners, and physician assistants) tend to be utilized much more frequently for specialty-type care such as treating mental disorders, orthopedic, and cardiac illnesses.
- Rates of health insurance are lower in rural areas than urban.
- Access to emergency services and the availability of specialty care are challenges in rural areas.
- People living in inner-city areas often lack access to health care because of a shortage of primary care providers, cultural barriers, lack of health insurance, and lack of awareness of available health services and how to access them.
- Rural residents visit a physician less often and later in the course of an illness than their urban counterparts.
- Preventive screening rates (such as mammograms, cholesterol, blood pressure checks), physical activity rates, and safety belt usage are lower in rural than in urban areas. However, it appears that leisure-time physical activity rates are higher (by 20%) in rural areas of the Northeast than their urban counterparts.
- Tobacco addiction rates are higher in rural areas versus urban and urban fringe areas.
- Injury-related deaths are 40% higher in rural populations than urban.
- Deaths from suicide are at higher rates in rural areas than urban.
- Heart disease, cancer, and diabetes rates are higher in rural areas than urban.
- Limitation in activity due to chronic health conditions among adults is more common in rural areas than urban.

- Some of our country's highest death rates, including the highest infant mortality rates, are found in our most rural areas.
- People who live in the most rural areas (fewer than 10,000 people) and inner-city areas share several factors in common: higher rates of poverty, mortality, and poorer health status than their suburban counterparts.
(Urban and Rural Health Chartbook, National Center for Health Statistics, 2001.)

IN MAINE, WE KNOW:

- Maine ranks 38th nationally in population density.
- According to the 1990 Census, Maine, along with Vermont and West Virginia, were the states with the highest proportion of population classified as rural.
- Forty percent of Maine's population lives in three counties – Cumberland, Penobscot, and Androscoggin – which are all designated as metropolitan counties by the US Census Bureau. However, all three of these counties include a wide variety of demographics from densely populated cities (Portland, Bangor, and Lewiston-Auburn) to suburban areas to sparsely populated communities, with profiles more fitting of rural areas.

Percent Of Population Living In Rural Areas
(Using Census Bureau Definition Of Rural Areas As Counties Designated Nonmetropolitan)

	US	Maine
1900	60%	67%
1990	25%	55%
2000	20%	60%

Source: US Census.

- Rural counties tend to have older populations. For instance, people 65 years and older comprise 13–14% of the population in Cumberland, Androscoggin, and Penobscot Counties, whereas they comprise 17% of the populations of Aroostook, Piscataquis, and Washington Counties.
- Rural counties in Maine tend to have higher rates of poverty and lower median incomes. For instance, Cumberland, Androscoggin, and Penobscot Counties have 8–12% of their population living in poverty and median household incomes ranging from about $36,000 to $41,000. By contrast, Aroostook, Piscataquis, and Washington Counties have 14–18% of their population living in poverty and median household incomes ranging from about $25,000 to $29,000.
- Ethnic and racial minority populations vary between rural and urban counties in Maine. For instance, black and Asian populations tend to account for most racial minority populations in Cumberland and Androscoggin Counties. Native Americans account for most of the racial minority populations of Washington and Aroostook Counties.
- Rural areas of Maine tend to have fewer health care providers per population. For instance:
  - Cumberland County has about twice the density of primary care allopathic physicians (MDs) than Oxford, Piscataquis, and Washington Counties (97 per 100,000 versus 43, 49, and 53 per 100,000 respectively).
  - Cumberland County has over twice the density of dentists than Oxford, Piscataquis, and Washington Counties (72 per 100,000 versus 32, 33, and 31 per 100,000 respectively).
  - There are 39 Health Professional Shortage Areas (HPSAs) in Maine, which account for the majority (63%) of Maine's Primary Care Analysis Areas. Most HPSAs are in rural areas.

CHALLENGES

- Town of residence is collected by many health data systems including the Census, PRAMS, MHDO, the Cancer Registry, Vital Records, and Infectious Disease Reports; and it may soon be collected by BRFSS (see Health Data Section beginning on page 65).
- However, defining rural and urban areas in Maine is particularly challenging. Commonly used Federal definitions do not accurately reflect Maine's population distribution patterns. Consequently, we lack the ability to accurately assess many health indicators as they relate to degrees of urbanization and rurality in Maine.
- The US Office of Management and Budget (OMB) uses a definition for urban that includes population densities as well as social and economic integration factors. Their definition of Metropolitan Areas includes the entire county that an urban area is in. Using this definition, Cumberland, Penobscot, and Androscoggin counties are considered entirely Metropolitan Areas because they include the cities of Portland, Bangor, and Lewiston/Auburn. However, many of the communities in these counties have the demographic, social, and economic characteristics of rural areas.
- Likewise, the Census Bureau has defined densely settled Urbanized Areas and the contiguous areas as Urban Clusters. Using this definition in Maine, there are only three Urban Clusters – Portland, Lewiston/Auburn, and Bangor. Essentially, the Census Bureau's definition defines all non-urban areas as rural. As a result, this definition does not reflect gradations in our population density seen in small cities such as Augusta and Waterville.
- The Bureau of Health is committed to looking at populations and data on a rural-urban continuum. By working with partners around the State, the Bureau hopes to create a definition that will reflect the gradations in population densities seen in Maine, so that health data can be evaluated to reflect the impact of geographic residence on health status.
- The Bureau has analyzed BRFSS data using the OMB definition (urban counties versus rural counties), as well as some analyses using population density data by town. No significant differences have been detected so far between rural and urban residents of the BRFSS questions analyzed using these methods. Other methods, as mentioned above, are being explored.

Nathan Nickerson, Director Public Health Division, Health and Human Services Department, City of Portland

"I think the biggest challenge and opportunity for Maine's health professionals and communities is that we are entering into a time in which two important health issues are front and center. First, there is an emerging political will to address the need for health care coverage for all residents of Maine. Second, I believe there is an unprecedented interest in developing a functional local public health infrastructure throughout the State. If we can take advantage of these opportunities, and meet these challenges, we will have taken a giant step forward toward being equipped for a healthier Maine."

SEXUAL ORIENTATION
and other sexual minorities

NATIONALLY, WE KNOW:

- Sexuality and sexual orientation can be defined in terms of one's sexual behavior, or one's self-identity, or one's desire and attraction.
- There is a lack of population-based data on lesbians, gays, and bisexuals.
- Although transgender is not a sexual orientation – it is considered by many a social identification, as the opposite of one's own anatomical sex – very often transgender populations are considered along with lesbians, gays, and bisexuals as a sexual minority population. There is a tremendous lack of population-based data on transgender people.
- Lesbians may have higher rates of smoking, overweight, alcohol abuse, hormone exposure, and stress than heterosexual women.
- HIV/AIDS and other sexually transmitted diseases, substance abuse including tobacco addiction, depression, and suicide are major health issues for gay men.
- Gay male adolescents are 2–3 times more likely than their peers to attempt suicide. In general, suicidal ideation and attempts have been shown to be 3–7 times higher among lesbian, gay, bisexual, and transgender youth.
- Studies have shown HIV prevalence rates ranging from 22–47% among male-to-female transgendered in urban areas in the US.
- Some bisexual women may be at higher risk for HIV/AIDS than heterosexual women.
- The issues of personal, family, and social acceptance of sexual orientation can place burdens on mental health and personal safety.

Betsy Smith, Executive Director, Maine Lesbian Gay Political Alliance

"It is essential to the health and well-being of gay, lesbian, bisexual and transgender youth to see public support for GLBT people. For example, health centers that positively address sexual orientation and gender expression, religious venues that openly welcome GLBT people, and schools that promote and value diversity, are areas where GLBT youth seek positive validation for who they are."

IN MAINE, WE KNOW:

- According to the 2000 Census, Maine ranks 6th in the nation in the proportion of same-sex couples (0.53% or 6,757 people).
- Maine counties with the largest proportion of same-sex couples include Cumberland, Piscataquis, and Washington.
- One in twelve (8.4%) of high school respondents to the Maine Youth Risk Behavior Survey reported they had had sexual contact with someone of the same gender.

Adolescents/GLBTQ

Penthea Burns, Maine Youth Leadership Advisory Team Coordinator, Portland, along with Alana, 19; Danni, 18; and Crystal, 20; who are members of the Team and students at USM.

Danni: *Transportation for youth in foster care or independent living isn't accessible. It's very hard to get to an appointment that isn't in the immediate vicinity which is a special issue if you need a doctor or dentist that accepts Medicaid. People from families without health insurance don't have a lot of transportation access either. Poverty and transportation issues seem to go hand in hand.*

Alana: *Inpatient care facilities are few and far between and nobody can afford that care for an adolescent. It's very frustrating for parents and kids. There shouldn't have to be a decision between crisis management and being able to feed your siblings.*

Penthea: *There's another potential barrier to health care with GLBTQ regarding "coming out:" Is your provider friendly? How do you know that what you say to them will be private? What are the implications of whether or not you have privacy? The heterosexist assumption is huge. It's a greater risk for youth because if you come out to your doctors, are they going to tell your parents or the people you're living with? With teens coming out at a younger age, the risk of homelessness has skyrocketed for adolescents whose parents aren't ready for their coming out even if the person is young. That's a major health concern right there.*

Danni: *There are many internalized phobias in the gay community. Once the heterosexist assumption is made, many gay men feel the necessity to maintain it. If you can't talk to your doctor about who you have sex with, you won't get the information you need. There's a teachable moment in a doctor's office where a doctor can explain that MSM (men having sex with men) is a high-risk category and what to do to reduce the risk. That moment is totally destroyed as soon as the heterosexist assumption is made.*

Alana: *Even if you're not GLBTQ, there's still a stigma attached to having sex before marriage – so even talking to a doctor about birth control is going to be hard for a lot of a adolescents. I have friends who have not talked about birth control with their physican because of the fear that it would get back to their parents. It's a bad situation if you're pregnant at 15 or have an STD. It makes a bad situation worse to worry about who you can trust. A lot of GLBTQ people are not going to have access to counselors, therapists or allies in the community or in their own family. A physician has the opportunity to be that person who can talk about the issues and give valuable medical information about being sexually safe. A physician can be the one person in that adolescent's life he or she can talk to honestly.*

Penthea: *School nurses have that same opportunity to be there as someone to confide in, and also be a link to resources and health education information that adolescents might need.*

Crystal: *I can't wait until I'm 25 and have a regular full-time job with health benefits so I can go to a doctor I enjoy, not have to worry about if they take Medicaid, know that I can pick any doctor I want and have that rapport we're talking about. If doctors would think of people as people and not as cases and make an effort to get to know their patients, they would ultimately help more people.*

- Seventy-three percent (73%) of a sample of Maine youth surveyed said that people who know them would perceive them to respect the beliefs and values of people who are of a different sexual orientation than they are.

  (Maine Marks 2000 and 2001 survey, Maine Department of Education.)

- Fifty-seven percent (57%) of people living with diagnosed HIV in Maine are men who have sex with men (MSM).

- In the recent (2001 and 2002) Maine outbreak of gonorrhea, about half of the cases are among men who have sex with men.

- A 1999 qualitative study of 21 rural Maine lesbians age 54–75 found poverty and lack of health insurance were key issues. Many preferred health care providers who are lesbian.

  (Sandra S. Butler, Barbara Hope, Health and Well-Being for Late Middle-aged and Old Lesbians in a Rural Area, *Journal of Gay and Lesbian Social Services*, vol. 9(4) 1999.)

CHALLENGES:

- Very few of our health data systems ask sexual orientation. The Maine Youth Risk Behavior System, the US Census, Bureau of Health's Infectious Disease Reports ask sexual orientation in very limited or indirect ways (see appendix). The Bureau of Health's Breast and Cervical Program also collects some information on sexual orientation.

- There are no standard definitions for delineating sexual minority populations. For instance, definitions can be based on sexual behavior, self-identity, desire, and attraction.

- As a result, there is a scarcity of information on the health of Maine's gay, lesbian, bisexual, and transgender populations.

- Because of social stigma, many people may be reluctant to share information regarding their sexual orientation or transgender identity with surveyors or their health care providers. This may also contribute toward a lack of data and understanding of health disparities.

- The Bureau is committed to working with collaborators around the State to find appropriate ways to measure the impact sexual orientation and gender identity have on the health of Maine people.

Rick Galena

"One health challenge is that providers don't necessarily know the sexual orientation of their patients. This can prevent them from asking certain questions, probing for certain risk behaviors, or looking for indications of a particular illness – which does a disservice to their patients. Bias and a lack of sensitivity to the gay and lesbian community continue to be major challenges for health care professionals."

Sexual orientation is often considered the deep-seated direction of one's sexual attraction. There is not a set of absolute categories, but a continuum. Included in this continuum are heterosexuality (sexual, emotional, and/or romantic attraction to a sex other than one's own), homosexuality (sexual, emotional, and/or romantic attraction to the same sex), or bisexuality (sexual, emotional, and/or romantic attraction to two sexes or two genders).

Gender identity is the gender that a person sees himself or herself as, regardless of external genitalia. Gender is, therefore, a social construct, and can change over time. Like sexual orientation, gender is on a continuum, and not an either/or concept. People who identify as "transgender" are generally felt to be people whose gender identity differs from the social expectations for the physical sex they were born with (e.g., women who feel like or identify as men). Some also use this term as an umbrella term to refer to anyone who transcends the traditional concept of gender. Transgender is also used sometimes to refer to those who cross-dress.

Sexual identity (also sex identity) is how one sees oneself physically: male, female, in between, or not identified. Some also define this term as how one thinks of oneself in terms of whom one is sexually and romantically attracted to. Transsexual generally refers to a person who experiences a mismatch of the sex they were born as and the sex they identify as. Sometimes they undergo medical treatment to change their physical sex to match their sex identity. Sometimes transsexual refers only to those who have chosen medical treatment.

It should be noted that there are different definitions of the above terms, depending on the sources one is using. Also, as understanding of gender and sex have changed, so have these definitions. However, the definitions included above are meant to provide some clarity on some concepts that can be confusing.

(Sources: www.usm.maine.edu/glbtqa/definitions, www.metrokc.gov/health/glbt/definition/htm, www.lgbtrc.ucr.edu/trans_101.html, www.ci.sf.ca.us/sfhumanrights/tg_guide.)

HOW *are* HEALTH DATA COLLECTED *in* MAINE *on these* MAJOR FACTORS LEADING *to* HEALTH DISPARITIES?

	CENSUS	BRFSS	YRBS	PRAMS	MHDO	MCR
Age	Y	Y	Y	Y	Y	Y
Disability Status	Y	Y	N	N	N	N
Gender	Y	Y	Y	Y	Y	Y
If Employed	Y	Y	N	N	N	N
Type of Employment	Y	N	N	N	N	Y
Veteran Status	Y	Y	N	N	N	N
Race	Y	Y	Y	Y	N	Y
Ethnicity	Y	Y	Y	Y	N	Y
Town of Residence	Y	N[1]	N	Y	Y	Y
Income	Y	Y	N	Y	N	N
Education level	Y	Y	Y	Y	N	N
Sexual Orientation	Y[2]	N	Y	N	N	N

Y = Yes, does collect this information N = No, does not collect this information

1 Town of Residence for BRFSS: BRFSS asked town of residence in 2000; but otherwise asks county of residence and notes the telephone exchange, which correlates with town. BRFSS will specifically ask town of residence in 2003 and years thereafter.

2 Census does not ask sexual orientation per se, but records same sex partners in the same household.

	BRTH	DTH	AB	MAR[9]	ID	TDS	MYDAUS
Age	Y	Y	Y	N	Y	Y	Y
Disability Status	N	N	N	N	N	Y	N
Gender	Y	Y	Y[5]	N[6]	Y	Y	Y
If Employed	N	N	N	N	N	Y	N
Type of Employment	Y[3]	Y[4]	N	N	N[7]	N[8]	N
Veteran Status	N	Y[4]	N	N	N	Y	N
Race	Y	Y	Y	Y[6]	Y	Y	Y
Ethnicity	Y	Y	Y	N	Y	Y	Y
Town of Residence	Y	Y	Y	Y[6]	Y	N	N
Income	N	N	N	N	N	Y	N
Education level	Y	Y	Y	Y[6]	N	Y	Y
Sexual Orientation	N	N	N	N	N[7]	N	N

3 "Usual occupation past year" and "usual business/industry past year" are asked on birth certificates, but are not entered or coded into Vital Statistic computer system.

4 Decedent's usual occupation (kind of work done during most of working life), kind of business/industry, and veteran status ("was decedent ever in US armed forces") are asked on the death certificate, but are not entered or coded into the Vital Statistic computer system.

5 Abortion certificates do not ask gender, but it is assumed all people receiving an abortion are female.

6 Gender per se is not asked on the marriage certificate. However, the certificate asks that the bride and groom be identified. Bride and groom's race, education, and county/town of residence are asked on the marriage certificate, but are not entered or coded into the Vital Statistic computer system. Race is asked by providing a blank space to be filled in, with the examples of "American Indian, Black, White, etc." given.

7 ID Reports ask type of employment if the infectious disease being reported is a hepatitis A or another foodborne illness. ID Reports also ask sexual orientation for sexually transmitted diseases.

8 TDS asks general questions regarding primary and secondary sources of income (none, wages/salary, retirement, alimony, TANF, SSI, unemployment, etc.)

9 Divorce Certificates do not ask age, ethnicity, race, education, income, employment, etc. It mainly asks names, place of residence, and names of children.

LEGEND

Census	2000 US Census data
BRFSS	Maine Behavior Risk Factor Surveillance System, Bureau of Health, Maine Department of Human Services
YRBS	Maine Youth Risk Behavior System, Maine Department of Education
PRAMS	Pregnancy-Related Monitoring System, Bureau of Health, Maine Department of Human Services
MHDO	Maine Health Data Organization, Maine Department of Financial and Professional Regulation
MCR	Maine Cancer Registry reports, Bureau of Health, Maine Department of Human Services

Vital Records maintained by the Bureau of Health, Maine Department of Human Services:

BRTH	Birth Certificates
DTH	Death Certificates
AB	Abortion Certificates
MAR	Marriage Certificates

Divorce Certificates are also considered a Vital Record.

ID	Infectious Disease Reports of those infectious diseases reportable by law to the Bureau of Health, Maine Department of Human Services
TDS	Office of Substance Abuse Treatment Data System, Maine Department of Behavioral and Development Services
MYDAUS	Maine Youth Drug and Alcohol Use Survey, Office of Substance Abuse, Maine Department of Behavioral and Developmental Services

How RACE and ETHNICITY are asked in these data sets:

The 2000 Census

RACE:

What is this person's race? Mark one or more races:

White; Black, African American, or Negro; American Indian or Alaskan Indian – print name of enrolled or principal tribe: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander (print race), Other Asian (print race), Some other race (print race).

ETHNICITY:

Is this person Spanish/Hispanic/Latino? If yes, check if Mexican, Mexican American, Chicano; Puerto Rican; Cuban; or other Spanish/Hispanic/Latino.

What is this person's ancestry or ethnic origin? (print ethnicity; some examples are given, such as Italian, Jamaican, African American, Cambodian, Cape Verdean, Norwegian, etc.)

Behavioral Risk Factor Surveillance System (BRFSS)

RACE:

Which one or more of the following would you say is your race?

American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other

Which one of these groups would you say best represents your race?

American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other
Don't know/Not sure
Refused

ETHNICITY:

Are you Hispanic or Latino?

Yes, No, Don't know/Not sure, Refused

Maine Youth Risk Behavior System (YRBS)

How do you describe yourself? (Select one or more responses)

American Indian or Alaskan Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White

Has anyone ever made offensive racial comments or attacked you based on your race or ethnicity – at school or on your way to or from school?

YES NO

Pregnancy-Related Monitoring System (PRAMS)

Information in PRAMS on race and ethnicity is obtained from birth certificates.

Maine Health Data Organization (MHDO)

Data is collected from claims forms, which do not ask race and ethnicity.

Cancer Registry (MCR)

RACE:

Since hospital records are the source of this information and hospitals in Maine vary on how and if they ask race, racial status is ascertained in various ways, depending on what information is available from the hospital records.

ETHNICITY:

For ethnicity, the possible selections are Mexican, Puerto Rican, Cuban, South or Central American (except Brazil), other Spanish, Spanish surname, Unknown, and Non-Spanish.

Birth Certificates (BRTH)

RACE:

The form asks for person to specify in blank spaces for race for each parent, giving examples of "American Indian, Black, White, etc."

ETHNICITY:

The forms ask to specify in blank spaces for ethnicity for each parent, giving examples of "French, English, Irish, etc."

Note: If more than one race or ethnicity are entered, only the first is used. However, this practice will change to include all listed races and ethnicities.

Death Certificates (DTH)

RACE:

The form asks for person to specify in blank spaces the race, giving examples of "American Indian, Black, White, etc."

ETHNICITY:

The form asks to specify in blank spaces the ancestry, giving examples of "French, English, Irish, etc."

Abortion Certificates (AB)

RACE:

The form asks for person to check American Indian, Black, White, or Other, and to specify race if "Other."

ETHNICITY:

The form asks for the person to fill in Ancestry, with the examples given of French, English, Irish, etc.

Marriage Certificates (MAR)

RACE:

The form asks for groom and bride's race to be filled in, giving examples of "American Indian, Black, White, etc."

ETHNICITY:

Ethnicity is not asked.

Infectious Disease Reports (ID)

RACE:

Race is circled using the following choices: "American Indian or Alaskan Native/Asian or Pacific Islander/Black/White/Unknown"; or race is left blank for the reporting person to fill in.

ETHNICITY:

Ethnicity is asked: "Hispanic? Y N" (circle one)

Treatment Data System (TDS)

RACE:

White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

ETHNICITY:

Not Hispanic or Latino; Hispanic or Latino

Maine Youth Drug and Alcohol Use Survey (MYDAUS)

RACE:

What is your race?

White, Caucasian or European
Black or African American
Asian or Pacific Islander
Chinese
Japanese
Korean
Asian Indian
Cambodian
Vietnamese
Other Asian
Filipino
Samoan
Hawaiian
Guamanian
Other Pacific Islander
American Indian or Alaskan Native
Other (Please Specify)

Please choose the ONE answer that BEST describes what you consider yourself to be:

White, not of Hispanic Origin
Black or African American
American Indian/Native American, Eskimo or Aleut
Spanish/Hispanic/Latino
Asian or Pacific Islander
Other (Please Specify)

ETHNICITY:

Are you Spanish/Hispanic/Latino?

No, not Spanish/Hispanic/Latino
Yes, Mexican American
Yes, Mexican
Yes, Chicano
Yes, Puerto Rican
Yes, Cuban
Yes, Central or South American
Yes, Other Spanish/Hispanic/Latino

How DISABILITY status is asked in these data sets:

2000 Census:

Does this person have any of the following long-lasting conditions:

Blindness, deafness, or a severe vision or hearing impairment?

A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying?

Because of a physical, mental, or emotional condition lasting six months or more, does this person have any difficulty in doing any of the following activities:

Learning, remembering, or concentrating?
Dressing, bathing, or getting around inside the home?
(*Answer if this person is 16 years old or over.*) Going outside the home alone to shop or visit a doctor's office?
(*Answer if this person is 16 years old or over.*) Working at a job or business?

Maine Behavior Risk Factor Surveillance System (BRFSS)

*The following question was asked by Maine BRFSS in **2000**:*

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

None, Don't Know/Not Sure, Refused, Number of Days

*The following questions were asked by Maine BRFSS in **2001**:*

Are you limited in any way in any activities because of physical, mental, or emotional problems?

During the past 30 days, did poor physical or mental health keep you from doing your usual activities such as self-care, work, or recreation?

Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

Yes, No, Don't Know/Not Sure, Refused

*The following questions are going to be asked by the Maine BRFSS in **2003**:*

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Number of days, None, Don't Know/Not Sure, Refused

Are you limited in any way in any activities because of physical, mental, or emotional problems?

Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

Yes, No, Don't Know/Not Sure, Refused

A more thorough disabilities module of questions is being planned for Maine BRFSS for a future year.

Treatment Data System (TDS)

Treatment Data Systems for substance abuse treatment

Are any special accommodations needed to provide services?

Yes or No answer for the following items: hearing, visual, physical, language, or other

How SEXUAL ORIENTATION is asked:

The 2000 Census

The 2000 Census does not identify sexual orientation of respondents but does identify some numbers of same sex partners living in the same household. The "householder," the individual in whose name the house is owned or rented, was asked to identify how other people in the household are related to the householder. Categories included spouse, child or other relative of the householder, housemate/roommate, roomer/boarder, and unmarried partner. Those identified as spouse or unmarried partner and found to be of the same sex were then designated as "same-sex partners." The 2000 Census numbers of same-sex partners are felt to be an undercounting, since some couples would be reluctant to report and since some may not live together.

The 2001 YRBS asked:

What is your sex?

female male

The person(s) with whom you have had sexual contact during your life is:

a. I have never had sexual contact
b. Female
c. Male
d. Male and female

Has anyone ever made offensive comments or attacked you because of your perceived sexual orientation – at school or on your way to or from school?

a. Yes
b. No

ID Reports ask:

For Hepatitis, "What is the patient's sexual preference?"

For HIV/AIDS, "What is the gender of sexual partners?"

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